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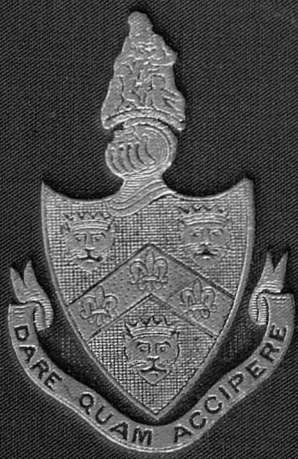

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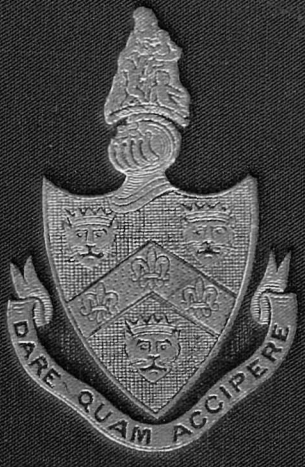

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GUY'S HOSPITAL GAZETTE.

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Passim.

THE Christmas festivities this year were marked by the high standard attained by local talent, and especially was this apparent on Christmas Day when the Niggers made their annual round. Mr. Biddle, picturesquely attired as Sir John Falstaff, made an excellent Massa Johnson, while the inimitable Mr. Woodruff added considerably to his already great reputation. Messrs. Woodruff, Groves, Lyne, and Brown, as "The Four Negative Swabs," distinguished themselves greatly both individually and collectively, and no doubt were the backbone of this year's troupe. But perhaps the greatest credit of all is due to Mr. Siggs, who so patiently and tactfully conducted all the practices, and without whose accompaniment the majority of the performers would have been entirely lost. The costumes this year were extremely good, as is borne out by the photograph which appears in this issue.

A NEW and pleasing feature of the Ward concerts this year was the appearance of a concert party of Guy's men, ingeniously styled "The Brockley Bruits," who willingly and untiringly gave their services when and wherever required. They are to be congratulated on the excellence of their performance, and the thought has occurred to many that their talent will be very welcome to next year's Niggers!

WITH the death of Sir William Osler, the whole of the medical profession, from the humblest student to the most eminent professor, has suffered the loss of one of the most striking and notable figures in modern medical history. Sir William has often visited Guy's, and the contributions from his pen to the GAZETTE have formed some of the most interesting articles we have published.

But he is probably best known to recent generations as author of "The Principles and Practices of Medicine," a book whose perfect English and clarity of expression constitute it a classic only equalled by such works as those of Hilton, Fagge, or Laënnec. On both sides of the Atlantic the world mourns one of the greatest minds, as well as one of the greatest benefactors of mankind, that the past century has produced.

A GENERAL meeting of the Residents and students of this Hospital was held on January 5th to discuss the means of collecting money in order to present Sir Cooper Perry with some fitting testimonial on his departure from

his present residence in the Quadrangle. It was decided to ask qualified men to give 10s. each, unqualified men in the wards 5s. each, and men not yet in the wards 2s. 6d. each. Furthermore it was decided to have an album in which subscribers should sign their names to go with the testimonial. The actual nature of the gift was not definitely settled, but this will be decided later. Messrs. Shaw and O'Meara kindly consented to collect from men in the wards, and Messrs. Sorabjee and Gallagher from those who had not yet reached that stage in their curriculum. Old Guy's men are requested to send their subscriptions, with their signatures, to Mr. Curry at the Counting House.

Other sections of the Hospital community have expressed a desire to cooperate in this scheme. Thus it is hoped that the testimonial, whatever form it may take, will be expressive of the good wishes and esteem which everyone about the Hospital, however humble or exalted his position, bears towards Sir Cooper Perry.

On the afternoon of January 29th there will be an assembly in the Court Room, at which the presentation will be made. More definite arrangements will be announced later.

SOME time ago there was expressed a general desire to hold a dinner for the present residents and students of this Hospital. A representative committee was formed, which met on Tuesday last. It was then decided to hold the dinner at the end of the month. Tickets will be approximately 10s. 6d. Evening dress will be optional. Mr. Bromley has kindly consented to occupy the chair. We have been requested to ask all men who intend coming to give in their names to Mr. Winston at the Wills Library, as soon as possible, in order that the necessary arrangements can be made. It is hoped that all who can will make a special effort to be present. The proceedings will be more or less informal, and a very happy evening should be spent.

MAY we take this opportunity of expressing our appreciation to all those who responded so splendidly to our appeals for funds for the Out-Patient Tea. Had they been in "Outers" on Christmas Day they would have been amply rewarded.

SEVERAL complaints have been made against the still prevalent custom of referring to Miriam Ward as "Clinical," both colloquially and on such official notices as the P.M. board. Now that Clinical has been re-commenced in in the medical wards, considerable confusion has been caused. Until the new Clinical has been built, perhaps it would be as well to cease applying the name to any ward, and to use the actual name of the ward instead.

ALL Guy's men must be pleased to hear of Lieut.-Col. F. E. Fremantle's success in the recent election at St. Alban's. The new member has the best wishes of his old Hospital in his future Parliamentary activities.

WE would remind our readers that the annual subscriptions to the Gazette, and to the Gazette and Reports for the year 1920 are now due, and should be sent to the Manager, Gazette Office, Guy's Hospital, S.E. 1. The subscription for the Gazette alone is 7s. 6d. per annum, and the Gazette and Reports 12s. 6d. per annum.

Appointments.

Civil.

Horace Mather to be Hon. Asst. Ophth. Surgeon, Eye and Ear Infirmary, Myrtle Street, Liverpool.

THE NIGGERS, 1919.

By kind permission of Mr. BANNOUNAH, Guy's Hospital.

Poliomyelitis.

CLINICAL LECTURE BY DR. H. C. CAMERON.

THE DIFFICULTY OF DIAGNOSIS.

I show you a map indicating for each borough in the London area the number of cases notified as having suffered from acute anterior poliomyelitis in the year 1914. You see how low the figures are. In our own Hospital area they are especially few—in Bermondsey 1, in Southwark 4. I make no doubt that the actual figures, if all cases were diagnosed, would be many times as great. Only on this assumption can we explain the disproportionately large number of cases, derived from the same districts, which present themselves at the hospital for the treatment of permanent paralysis, long after the acute stage is over—forgotten or remembered only as a preceding attack of "influenza," "rheumatism," or "meningitis." There are cases in which not even admission to hospital makes the diagnosis clear, and from time to time an infant is brought to me in the Out-patient Department with the complaint that ever since discharge from hospital a leg or arm has shown loss of power, and this although the ward report speaks only of bronchitis or of diarrhœa. No doubt a case of gross paralysis is not likely to be thus overlooked, but it is otherwise with a slight or limited paresis in a little child who has not yet walked, whose lack of vigorous movement and flaccid limbs may well be explained as part of the general disturbance, and whose muscles are so ill developed or so plentifully covered with fat that it is not easy to detect wasting. Unless some special examination is directed to muscles and to movements, it is not difficult to conceive that even in hospital the paresis is not detected, and the true nature of the illness not appreciated. Because of the frequency with which this happens, and because there is some evidence that the disease is more rife than usual at the present time, I think it may be worth while to spend this hour in considering the symptoms, diagnosis and treatment of poliomyelitis in the acute stage. Not that there is just now anything in the nature of a true epidemic. Sporadic cases of the disease are always with us. At the present time they seem to have been a little more frequent than usual. I show you charts in which the cases for the notified in the last four years are set out month by month. You see that the great majority of caess occur in the autumn, the maximum falling three times in September and once in October. This country has never as yet been devastated by a great epidemic of the disease, such as occurred in 1914 in New York, when there were over 8,000 cases with a death roll of over 2,000.

When such a great epidemic has occurred, attention has been called to the number of cases which are said to be abortive cases. The symptoms of an abortive case do not differ from the early symptoms, the pre-paralytic symptoms, of a case which is later to be followed by paralysis. In 1910 I saw two little sisters. Both had been ill for forty-eight hours with pyrexia, pains in the limbs, stiffness of the back, drowsiness and irritability. The younger recovered the next morning, the elder developed paralysis of which she still shows the effects. If we regard anterior poliomyelitis as an infective specific fever, then perhaps we must look upon the common lesion of the anterior cornual cells as a complication. Diphtheria is a specific fever which is also followed at times, though much less frequently by loss of power, yet we do not speak of a case of diphtheria in which no neuritis follows as an abortive case. I mean that it must be interesting—even if, because of the inevitable uncertainty of the diagnosis, perhaps not very profitable—to speculate how often the specific fever occurs in the absence of paralysis. In the nature of things abortive cases are only to be recognised during an epidemic when contact with undoubted cases gives the clue. It has been stated that they may then number 50 per cent. of the whole. For sporadic cases we have no evidence to guide us. We know only that as a rule sporadic cases are much milder than cases in epidemics, and this might lead us to expect that abortive cases would be more common.

SYMPTOMATOLOGY.

Besides fever, somnolence or irritability and gastro-intestinal disturbance, symptoms which are in no way suggestive, we have a few other manifestations which are more characteristic. I think I have been most struck by a certain rigidity of the spine which makes the attempt to sit up or to bend the back resented because apparently painful, and which yet lacks the opisthotonus and muscular hypertonus which

accompanies meningitis. I see that in the Report of the New York epidemic from the Rockefeller Institute this symptom was noted in 80 per cent. of all cases. I do not think it has been emphasised sufficiently in most descriptions which you will read. In the same Report mention is made of a frequent initial symptom with which I am not so well acquainted—certain twitchings or jerkings, seen very early, in the paralysed limbs as well as in the limbs which are about to be paralysed. The same symptom has been described by a French writer under the name Paralysis Infantile Choreic. In most cases there is at the outset complaint of pain or of tenderness in the limbs. Sometimes there are shooting pains like those of meningitis, sometimes pain on movement of the joints; sometimes hyperæsthia of the limb even to light pressure. In an abortive case which I saw, the pains were apparently quite as severe as in the cases which did develop paralysis.

In all cases where there seems reason to suspect poliomyelitis, a lumbar puncture should be performed. Fluids withdrawn very early in the disease show an increased cellular count with a low or normal globulin content. Later the globulin percentage rises. The polymorphonuclear leucocytes may at first show an increase, but soon a definite lymphocytosis establishes itself. All fluids reduce Fehling's Solution and are clear, not purulent. In tuberculous meningitis, as you know, the fluid is also clear, the globulin is in excess, there is a lymphocytosis, while the reduction of Fehling's Solution often fails. These distinctions between two conditions so apt in the early stages to be confounded clinically are not, as you see, very precise. At least it can be said of the examination of the cerebro-spinal fluid that it separates, usually though not invariably, two groups of cases with meningeal symptoms, (1) Cases in which the fluid is turbid and contains an increase in polymorphonuclear cells (2) cases in which the fluid is clear or only slightly cloudy and contains an increase of lymphocytes. The first group contains cases of acute infection with the meningococcus, the pneumococcus, the streptococcus, the influenza bacillus, the bacillus typhosus, the bacillus coli communis, etc. The second occurs in syphilis, in tubercle, in poliomyelitis, in sinus thrombosis, and in late cases of infective meningitis. Yet the distinctions are not always to be found. In my ward, just now, is a child with what appears to be cerebro-spinal meningitis of the posterior basic variety, yet the fluid has always been clear and without excess of polymorphonuclear cells, and, as has been said in the earliest stages, polymorphonuclear cells may predominate in anterior poliomyelitis.

NATURE OF THE PARALYSIS.

The paralysis due to anterior poliomyelitis has the following characteristics:

1. The lesion, though it may involve any part of the cerebro-spinal system, the cortex and medulla as the cord, in the majority of cases is found in the anterior cornual cells of the cervical and lumbar enlargements of the spinal cord. The common paralysis, therefore, is of lower neuron type with flaccidity and early wasting of muscles.

2. The onset may be described as *retrogressive*. That is to say, the paralysis tends to establish itself suddenly and at its maximum, and almost from the first begins to improve. In this it contrasts with peripheral neuritis, where the onset is *progressive*, spreading and increasing from day to day. Rarely in anterior poliomyelitis do we find a paralysis spreading from limb to limb or renewing its attack after a short interval. Landry's ascending paralysis is probably often if not always such an anomalous case of anterior poliomyelitis.

3. The motor paralysis is not accompanied by any sensory disturbances, a second important point of contrast from peripheral neuritis.

4. The paralysis may be complete and severe, or it may be of slight degree and difficult to detect. It may be widely spread or confined to a single muscle or part of a muscle.

5. When, as often happens, the antagonistic group of muscles is unaffected or relatively unaffected, there is constantly present a tendency for the weakened muscles to be stretched by the contraction of the unopposed antagonists. To counteract this tendency is a main object in all treatment.

The lower limbs are more frequently paralysed than the upper. Paralysis of the extensors of the foot and of the flexors of the

thigh, and paralysis of the deltoid are the lesions which most frequently persist.

PERMANENT DEFORMITIES.

Permanent deformities as the result of contraction of antagonistic muscles may be very disabling. Some time ago Sir Alfred Fripp showed me in his wards a little boy of three, who was afterwards transferred to the Baby Ward. This child had never learned to walk. In infancy in all probability he had suffered from an attack of anterior poliomyelitis, with complete recovery except in the extensors of the thigh. As a result, the iliopsoas muscle had contracted, so that when he attempted to stand upright the body remained flexed on the legs, and the child could not bring his centre of gravity sufficiently far backwards to maintain his balance without the support of a hand stretched forward, holding on to a chair or table. In cases where the same defect is present but in much greater degree, the child becomes a quadruped, running freely on all fours, but unable to erect the trunk. In the reverse condition in which the iliopsoas muscle is paralysed and the extensor antagonists have become shortened and contracted, it becomes impossible to produce flexion at the hip. Locomotion of any sort then becomes very difficult. I show you a photograph of such a child as stiff as a ramrod, and held horizontally supported only at the heels and occiput. These are not common deformities. The usual persistent weakness is "drop foot." The degree of disability resulting from even a slight limitation of movement in the ankle joint is very striking. In walking, the foot which bears the weight of the body makes an angle with the leg, which at the beginning of a long stride is very obtuse, but which at the end has become very acute. A very little fixation of the joint shortens the stride very much, preventing its proper completion, for which extreme hyper-extension is necessary. Paralysis of the diaphragm is well shown in this X-ray plate. Paralysis of the abdominal muscles may result in a large hernia-like protrusion.

DIFFERENTIAL DIAGNOSIS.

The differential diagnosis has to be made from the different forms of pseudo-paresis in infancy, from birth paralysis, from multiple neuritis, and from at least some forms of meningitis.

1. By pseudo-paresis is meant the simulation of paralysis which takes place in a young infant, when there is a painful condition affecting a limb, especially in the neighbourhood of a joint or of the epiphyseal line. Two forms are common, one due to syphilis and one to infantile scurvy. Syphilitic epiphysis and periostitis occur in young infants, very seldom more than three months of age, and there are usually other signs of syphilis present at the same time. Infantile scurvy does not occur before the sixth month, and is most usually met with between the ninth and eighteenth months. In both it is easy to detect the thickening of the bone at the seat of the greatest tenderness and pain. In both the changes in the bones may be seen by means of the X-rays. I have here a plate of a child at present in the Children's Ward with infantile scurvy, showing a complete separation of the upper epiphysis of the humerus, and to compare with it a plate of the humerus of a child ten weeks old with congenital syphilitic periostitis. Confusion between infantile anterior poliomyelitis and pseudo-paresis should not occur.

2. Erb's paralysis, the most common form of birth paralysis, is due to rupture of the fifth and sixth cervical nerve roots, that is to say, of the upper part of the brachial plexus, in the act of birth. The obstetrical history of such cases usually reveals some difficulty in freeing a shoulder by traction on an arm while the head and neck are held pressed in the opposite direction. The resulting paralysis involves the deltoid subscapularis, supra- and infra-spinatus and biceps. The arm is therefore held in a characteristic position, extended, inwardly rotated and pronated. The palm points backwards with the wrist flexed, a position compared quite aptly to that of a waiter asking for a tip. This particular position, the result of paralysis involving so many muscles simultaneously, can seldom be imitated by anterior poliomyelitis.

3. In multiple neuritis the onset is progressive and not retrogressive, and it is usual to find some evidence of sensory involvement. Diphtheritic neuritis is that which most frequently gives rise to confusion, but the involvement pretty constantly of the soft palate and of the ocular muscles, giving rise to a nasal voice, regurgitation of food through the nose and to visual weakness from failure of accommodation or to squint will usually make

the diagnosis plain. Lead, arsenic and alcohol must be borne in mind as occasional causes of peripheral neuritis. Perhaps I ought to say that there have been cases in which it has been stated that the virus of anterior poliomyelitis has itself given rise to a peripheral neuritis. Such cases could only be diagnosed in the presence of an epidemic which served to give the clue.

4. From tuberculous or meningococcal meningitis the diagnosis may in the early stages be difficult. In tuberculous meningitis the prodromal period is as a rule much longer and the whole illness unfolds itself much more gradually. To distinguish the onset from that of meningococcal meningitis there are times when one must rely on the appearance of the cerebro-spinal fluid. In meningococcal meningitis the fluid is turbid and contains meningococci within the polymorphonuclear cells.

I should like here to refer to a peculiar experience which I have had recently, peculiar because of its apparent rarity. I have twice recently met with a case in which a confident diagnosis of anterior poliomyelitis had been made because of paresis in a lower extremity. The first was that of a little girl, four years old. I saw her up and about, convalescent, it was thought, from a slight pyrexial illness. The child had been noticed to be lame in the left leg. I demonstrated the weakness in the muscles. The achilles jerk was absent, the knee jerk very faint, and much less than on the sound side. A neurologist who also saw her agreed that she had had a mild attack of anterior poliomyelitis. Two weeks later I saw her again. She had begun to show the signs typical of tuberculous meningitis, of which she died. Some time later I made a post-mortem examination upon a boy who had been admitted to Addison for a similar loss of power in the left leg. No one who saw the child had had any doubt but that he was suffering from anterior poliomyelitis. After three weeks he was about to be discharged well or at least greatly improved when again the temperature rose and again the symptoms of typical tuberculous meningitis slowly developed, and he died in coma. At the autopsy in addition to recent tuberculous meningitis at the base of the brain there was lymph of some standing over the lumbar enlargement of the cord. I show you a very beautiful section for which I am indebted to Mr. Cohen. It shows that the anterior cornual cells in the lumbar centre are healthy. They are well shaped, stain well, and show Nisl's granules, but there is much lymph heaped up on the issuing nerve roots, and here and there a typical giant cell system. In how many cases of cerebral tuberculous meningitis do we examine the cord? In how many is it involved? In these two cases it would appear that not only was the cord involved but that the disease there preceded by some time the involvement of the brain in the usual situation. From the accident that these two cases have presented themselves within a comparatively short time I suspect that more examples will be met with if the point is borne in mind. If so, the differential diagnosis between tuberculous meningitis of the cord and and anterior poliomyelitis will be very difficult even with the help of the information to be derived from a lumbar puncture.

TREATMENT.

Lastly I come to the treatment and management of the acute stage. When it became known that Urotropine was broken down in the cerebro-spinal fluid and that formaldehyde could be recovered, it was advised that the drug should be given in large doses. Experience, however, has shown that it is of little benefit. Subdural injection of serum from a donor who has recovered from the disease has been tried, but with doubtful result. Aspirin is effective in controlling the pain. Rest in bed is essential. The child lies most comfortably in a partially flexed position. A pillow should be placed under the knees. Frequent changes of posture should be resorted to; the slightest change in the attitude of the joint may give relief for the time. Lumbar puncture is not only often necessary for diagnostic purposes, but it seems also to serve to relieve the acute symptoms at the onset. The principal object of treatment in the earliest stage of invasion and in the stage of gradual recovery of power is to prevent stretching of the weakened muscles. The adjustment of muscle tone between antagonistic groups of muscles is so fine that as soon as the nerve cell governing the action of one group is affected, the opponent group begins to overact. This overaction must be prevented both because it does not allow complete rest to the damaged anterior cornual cells, and because shortening of the muscle interferes

with recovery, and after recovery causes it to act at a mechanical disadvantage. Rest prone in bed supports a considerable number of the muscles which may be weakened and prevents this contracture of antagonists. In certain muscle groups mere confinement to bed is not enough. For instance, it does not prevent foot drop. In consequence weakness of the tibialis anticus and associated muscles is certainly the most common permanent disability, not so much because the toxin falls with peculiar severity upon the corresponding group of anterior cornual cells as because unless steps are taken to support the foot these muscles will be stretched by the contraction of the powerful muscles of the calf, and by the action of gravity. Similarly, the weight of the dependent arm if unsupported is bound to stretch a weakened deltoid. As temporary measures the weakened foot should be supported at right angles by a splint with a foot-piece, or the arm if affected should be bound to the side over an axillary pad. Ultimately in each case suitable plaster or celluloid splints must be fitted to support weakened muscles, to keep them in a position of relaxation and to prevent their being stretched. Where skilled supervision is available splints should be made so that they can be removed daily to permit of voluntary movements being practised. When this is done trained supervision is necessary to ensure that the weight of the limb is always adequately supported until all danger of stretching is over. It is a good plan, and one especially useful with little children, to allow the earliest attempts at voluntary movement to take place in the bath while the limb is buoyed up by the hydrostatic pressure of the water. By means of floating toys even the youngest child can be induced to make attempts at voluntary movements of particular muscles with safety. Massage and passive movements of the joints are valuable in maintaining the nutrition and mobility of the limbs during the time when voluntary impulses are interfered with. The advantages of the use of electrical treatment are more doubtful. The proceeding is generally resented by little children.

Honours.

C.B.E.—MILITARY DIVISION.

Bt. Major A. W. Ormond, F.R.C.S.

Leaves from a Medical Note Book (1914—1918).

X. Splenic Enlargement in Trench Fever.

In the later accounts of Trench Fever there is a general recognition that splenic enlargement is present in a very considerable proportion of cases. In the earlier accounts, however, this enlargement—actually the only objective physical sign in the disease—was not emphasised. It might be supposed that this was simply due to a less thorough investigation of cases in the earlier part of the war, but there is a definite impression among clinical observers that palpable splenic enlargement was very rare in 1915 and became increasingly common as the war progressed. It is unlikely that the sign would have been frequently missed at any time, for the following reasons—(1) In the very earliest account of the disease by Graham, attention was drawn to the left hypochondriac pain, which strongly suggested splenic involvement; (2) it was at all times so important to detect cases of typhoid-group infection that spleens were conscientiously sought for; (3) although not so numerous as they became later, cases of trench fever were very plentiful in 1915.

If there actually were an increase in the frequency of splenic enlargement it must be supposed either that the type or virulence of the infection had altered, or that chronic or repeated infections produced changes not so conspicuous in the initial cases. Against the second theory we have the fact that the cases experimentally produced in American volunteers in 1917 showed a high incidence of splenic enlargement.

The type of spleen tumour has not received much notice in the literature. The degree of enlargement was never great, the spleen seldom reaching more than one or two fingers' breadths below the costal margin on inspiration; in the cases with the left hypochondriac pain, the spleen could seldom be felt; in the cases in which the spleen could be felt there was seldom any pain, and even tenderness was often absent; the spleen was firm to the touch and presented a definite, almost a sharp, margin to the palpating hand. The enlargement usually corresponded with the pyrexial periods, and was not often found in afebrile cases. These features were all valuable in distinguishing it from the softer and more rounded spleen tumour of typhoid fever.

(To be continued.)

Ward Concerts.

ASTLEY-COOPER.

The usual concert was held on New Year's Eve, and to judge from the vocal and other expressions of pleasure was much appreciated. The programme was practically entirely drawn from local talent, and it compared very favourably with the others which relied on outside help. Misses Johnson, Dalbiac and Groom supplied some excellent vocal and instrumental music. Messrs. Gallagher, Sawday, Short and others sang excellently, while Messrs. Woodruffe and Groves gave some of their inimitable comic "stunts," which proved extremely popular. Sister Astley Cooper is to be congratulated on the excellent concert, the arrangements for which were beyond praise. The usual bonfire ushered in the New Year, and everybody we hope thoroughly enjoyed their last evening of 1919.

CHARITY AND LUKE.

The Christmas atmosphere found vent in these wards in a most excellent concert, kindly arranged by Mr. Corelli Windeatt, and held on Christmas Eve. The wards had been most beautifully decorated by the Sisters and Nurses. Tea was provided before the commencement of the concert in order to do away with an interval. The long and varied programme was opened by an overture played by Mr. Corelli Windeatt's orchestra, and this was followed by Mr. Shoreham singing "Come to the fair." Miss Helen Mar, who has been present at numerous Charity concerts, again told us many humerous stories and also recited. The orchestra then entertained the rapidly increasing audience to "Down on the Farm," and Mr. Findlay Dunn caused much amusement with his stories at the piano. Miss Marjorie Bristow, Miss Gladys Banks, and Mr. Walter Evans sang so well that encores were demanded. Mrs. Gerald Lawrence (Miss Fay Davis) recited, as did Mr. Gerald Lawrence, who brought the house down with his rendering of "The Warship Camperdown." A harp solo was played by Mr. Leonard, and an excellent concert was brought to an end by the orchestra playing "Sand Dunes." Sir Alfred Fripp proposed a very hearty vote of thanks to the numerous artists for the kind way in which they had consented to perform, although they were so busily occupied during the day.

ESTHER.

A concert was given in Esther Ward at 3 p.m. on Saturday, the 27th December, 1919. Mr. Peacock provided a very excellent concert party of outside talent. Mr. Fred Frampton,the celebrated comedian, was particularly appreciated, and gave numerous encores. Miss Rosalie rendered several admirable violin solos, and Miss Watts accompanied at the piano. After an excellent tea, provided by Sister Esther, the concert was carried on by local talent, of which the patients never seemed to tire, the concert lasting until 6.30 p.m. Mr. Woodruffe, as usual, brought down the house, and Mr. Frampton was heard to remark "He's no new hand at this game, you know," a very high tribute to his talent. The "Brockley Bruits" brought a very successful concert to an end with several excellent turns.

EYE.

Monday, December 29th, a very talented concert was held in the Eye Wards before a large and appreciative gathering, all seats being full even to the locker gallery seats at the back! Mr. Pat O'Meara has to be congratulated on his excellent programme, and we take this opportunity of thanking the several artistes who so kindly came to entertain us, space not permitting us to enlarge on their respective merits. We have to thank Sister and the Nursing Staff for an admirable tea, and the glimpse of loaded baskets of fruit which even the most audacious of us did not dare touch! After a very enjoyable afternoon the concert was brought to a close with the National Anthem.

NAAMAN AND DORCAS.

On Tuesday, December 30th, all hopes were amply rewarded by a magnificent entertainment. Miss Hullock's very able party entertained us for one and a-half hours, which was one period of continuous enjoyment. After an interval for tea, some beautiful selections from Gilbert and Sullivan operas were rendered by Miss Elsie Griffin and Mr. Arthur Lucas, of the D'Oyley Carte Opera Company. Mr. Pett Ridge amused everyone with some of his delightful stories, and, lastly, a few more excellent turns by the members of Miss Hullock's party brought a most enjoyable and successful concert to a close. Many thanks are due to Mrs. Rowlands for her help in obtaining the artistes.

STEPHEN.

After a very enjoyable tea, provided by Sister Stephen, a concert was held in the ward. The first part of the programme was rendered by a party brought by Miss Babbs, including two very excellent juvenile dancers. The local talent followed on, and was greatly appreciated by the patients. Mr. Braithwaite gave two very good turns, including an account of his experiences on the Stephen balcony at night. Needless to say, Mr. Woodruffe was a popular favourite, and with Mr. Groves helped to make the concert a great success. The Clinicals gave a topical song only second to the effort of the "Four Negative Swabs" in their rendering of "Italio de Lingo." Miss Toms sang delightfully, and Mr. Siggs at the piano was indispensable, and in spite of a hard Christmas week he gave himself up, in his usual generous manner, to the task of accompanying everyone.

Antiquarian Discoveries at Guy's Hospital.

POTTERY.

At the junction of the clay and in the Roman layer above a considerable number of fragments of pottery was found. These belonged to dishes, bowls, etc., of the Roman household, and were mainly of the provincial "terra sigillata" type known formerly as Samian ware. This is characterised by being composed of fine-grained red clay—harder than the Arretine pottery of Italy—and by a fine red glaze like coral or sealing-wax. Most of the pottery was made at centres in Gaul, and the names of the potters stamped on the bases of pieces found in London are in a large proportion of instances identical with those found in excavations on the Continent. The two centres in Gaul where this pottery was known to have been manufactured were (1) La GRAUFESENQUE (Condatomagus), near Rodez, in the Department of Aveyron, and (2) Lezoux, in the Puy de Dôme, Auvergne. The former pottery was made during the period A.D. 30 or even earlier to A.D. 100, overlapping after A.D. 70 with that made at Lezoux which remained in existence until A.D. 250. During the Second Century other potteries came into existence, notably at Rheinzabern, near Speyer, and lesser centres in Southern Bavaria. At these places only decorated work was manufactured. The remains unearthed at Guy's include specimens from all these localities.

The following is a list of the names of the potters identified, although in several instances the stamp was so faint as to be undecipherable, while in other instances only a part of the name was on the fragment obtained :—

1. SIINICIO. F.—Fragment of base. Diam., foot 3 3/8in. The two perpendicular strokes after the S represent E, while the F is an abbreviation for FECIT, often represented by MA, an abbreviation for MANU. Senicio was a potter of La Graufesenque.

2. VOGEN . F.—Base of dish. Potter of uncertain locality.

3. (C)RICIRO.—Fragment of base. A potter of Lezoux.

4. MOSSIMA.—Base, diam., foot 2in. Mossius, a potter of Lezoux.

5. DONNA(UCUS). —Fragment of base. Diam., foot 2in. A potter of uncertain locality.

6. PRID . FEC.—Base. Diam., foot 2in. Pridianus, a potter of uncertain locality.

7. ——ULUS. Fragment of base of dish. The name may have been that of REGULUS, a potter of uncertain locality, or PRIMULUS, a potter of Lezoux.

8. AV———. Base, diam., foot 3in. The name may have been (a) Aucella, of uncertain locality; (b) Aventinus, of Lezoux; or (c) AUSTER, an ornamented vase of this potter having been found in St. Thomas's Street some years ago.

9. POTI——.—Fragment of bowl. Unornamented. Diam., foot 3 7/8in. Probably POTITIANUS, of uncertain locality. Another possibility is the name POTTACUS, but in the known specimens there is doubt as to the spelling of this name.

10. MA——US . MA.—Fragment of base. Diam., foot 3in. This may have been Mascuius, who made plain ware at La Granfesenque, and Montans, but all the stamps of this maker in the British Museum have the initial M and A ligated, so that it seems more likely to have been the name of some Lezoux potter of whom several names commenced MA and ended in US.

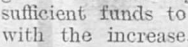
11. ——ORUS.—Fragment of a base. This part of the name may have belonged to a number of potters of Lezoux, possibly TORUS.

12. ——IAITIMO—.—This inscription was on a raised panel on a decorated fragment of a bowl known as type 37 of Déchelette. A few days later another similar fragment, bearing the stamp ——IMO), was unearthed. By reading the letters backwards it was found to be the name of COMITIALIS, a potter of Rheinzabern, who worked between A.D. 160 and A.D. 180. This is a rather rare and interesting stamp, although of comparatively late date.

13. D———S.—This was a stamp on an almost complete hemispherical bowl when the fragments were joined together. The diameter across the top is 5in., the foot 2in., and height 2½in. The bowl is not decorated. The stamp is almost undecipherable, and may have been that of DOECCUS. The final S is reversed, and assuming the D is really an O, the name may have been SACERO, but both interpretations are unsatisfactory.

14. MAXIM——.—Part of base. Diameter, foot 2 1/8in. The M and A are ligated. The stamp is that of MAXIMUS, a potter of uncertain locality.

A few other stamped bases were obtained, but they were more of the nature of trade-marks than a potter's name. In some cases a few strokes forming no letters was all that was present, while one stamp had a series of V's or U's fused together thus



(To be continued.)

East London Hospital for Children and Dispensary for Women.

JUBILEE FUND.

The district served by this Hospital has recently grown considerably; but unfortunately there are insufficient funds to enable the Hospital to keep pace with the increase. Will you help? £50,000 is required to extend and fully equip the Hospital.

Contributions will be gratefully received by

Major-General The Earl of Errol,
Hon. Treasurer.

or by

Mrs. C. F. Sargon,
Organising Secretary.

199, Piccadilly, W.1.

Notice.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC.

Queen Square, Bloomsbury, W.C.1.

POST GRADUATE COURSE:
January 19th to March 27th, 1920.

JANUARY.

Monday, 19th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Dr. S. A. Kinnier Wilson. Examination of the Nervous System and Interpretation of Physical Signs. I.

Tuesday, 20th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Ward Cases, Dr. James Taylor.

Wednesday, 21st.—2 p.m., Mr. Scott, Tinnitus aurium; 3.30 p.m., Dr. Greenfield, Pathological Demonstration.

Thursday, 22nd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Dr. S. A. Kinnier Wilson. Examination of Nervous System and Interpretation of Physical Signs. II.

Friday, 23rd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Hinds Howell.

Saturday, 24th.—9 a.m., Surgical Operations.

Monday, 26th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Dr. S. A. Kinnier Wilson, Examination of Nervous System and Interpretation of Physical Signs. III.

Tuesday, 27th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Ward Cases, Dr. Risien Russell.

Wednesday, 28th.—2 p.m., Mr. Scott, Auditory Vertigo and Forced Movements; 3.30 p.m., Dr. Greenfield, Pathological Demonstration.

Thursday, 29th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m. Dr. S. A. Kinnier Wilson, Examination of Nervous System and Interpretation of Physical Signs. IV.

Friday, 30th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Tooth.

Saturday, 31st.—9 a.m., Surgical Operations.

FEBRUARY.

Monday, 2nd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Dr. Aldren Turner, Paraplegia. I.

Tuesday, 3rd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Ward Cases, Dr. James Taylor.

Wednesday, 4th.—2 p.m., Mr. Armour, Surgical Treatment of Cerebral Tumours. I.; 3.30 p.m., Dr. Greenfield, Pathological Demonstration.

Thursday, 5th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Dr. Saunders, Syringomyelia.

Friday, 6th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Hinds Howell.

Saturday, 7th.—9 a.m., Surgical Operations.

Monday, 9th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Dr. Aldren Turner, Paraplegia. II.

Tuesday, 10th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Ward Cases, Dr. Risien Russell.

Wednesday, 11th.—2 p.m., Mr. Armour, Surgical Treatment of Cerebral Tumours. II.; 3.30 p.m., Dr. Grainger Stewart, Disseminated Sclerosis.

Thursday, 12th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Dr. Saunders, Progressive Muscular Atrophy.

Friday, 13th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Tooth.

Saturday, 14th.—9 a.m., Surgical Operations.

Monday, 16th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Mr. Paton, Optic Atrophy.

Tuesday, 17th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Ward Cases, Dr. James Taylor.

Wednesday, 18th.—2 p.m., Mr. Armour, Surgical Treatment of Cerebral Tumours. III.; 3.30 p.m., Dr. Grainger Stewart, Disseminated Sclerosis. II.

Thursday, 19th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Dr. Farquhar Buzzard, Intracranial Tumours.

Friday, 20th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Collier.

Saturday, 21st.—9 a.m., Surgical Operations.

Monday, 23rd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Mr. Paton, Ophthalmoplegia.

Tuesday, 24th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Ward Cases, Dr. Risien Russell.

Wednesday, 25th.—2 p.m., Mr. Sargent, Surgical Treatment of Spinal Caries; 3.30 p.m., Dr. James Taylor, Epilepsy.

Thursday, 26th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Dr. Farquhar Buzzard, Intracranial Tumours. II.

Friday, 27th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Tooth.

Saturday, 28th.—9 a.m., Surgical Operations.

MARCH.

Monday, 1st.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Ward Cases, Dr. Aldren Turner.

Tuesday, 2nd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Dr. Risien Russell.

Wednesday, 3rd.—2 p.m., Mr. Sargent, Injuries of Peripheral Nerves and their Surgical Treatment. I.; 3.30 p.m., Dr. James Taylor, Subacute combined degeneration of Spinal Cord.

Thursday, 4th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Dr. Hinds Howell, Syphilis of the Nervous System. I.

Friday, 5th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Ward Cases, Dr. Collier.

Saturday, 6th.—9 a.m., Surgical Operations.

Monday, 8th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Ward Cases, Dr. Saunders.

Tuesday, 9th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Dr. Risien Russell.

Wednesday, 10th.—2 p.m., Mr. Sargent, Injuries of Peripheral Nerves and their Surgical Treatment. II.; 3.30 p.m., Dr. Hinds Howell, Syphilis of the Nervous System. II.

Thursday, 11th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Ward Cases, Dr. S. A. Kinnier Wilson.

Friday, 12th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Dr. Gordon Holmes, Ataxia.

Saturday, 13th.—9 a.m., Surgical Operations.

Monday, 15th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Ward Cases, Dr. Aldren Turner.

Tuesday, 16th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Dr. Tooth, Poliomyelitis.

Wednesday, 17th.—2 p.m., Dr. Yealland; 3.30 p.m., Dr. Collier, Aphasia and Apraxia. I.

Thursday, 18th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Ward Cases, Dr. S. A. Kinnier Wilson.

Friday, 19th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Dr. Gordon Holmes, Cerebellar Disease. Ataxia. II.

Saturday, 20th.—9 a.m., Surgical Operations.

Monday, 22nd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Collier; 3.30 p.m., Ward Cases, Dr. Aldren Turner.

Tuesday, 23rd.—2 to 3.30 p.m., Out-patient Clinic, Dr. Grainger Stewart; 3.30 p.m., Dr. Tooth, Eucephalitis.

Wednesday, 24th.—2 p.m., Demonstration of Fraenkel's Exercises by Mr. Elmquist; 3.30 p.m., Dr. Collier, Aphasia and Apraxia. II.

Thursday, 25th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Farquhar Buzzard; 3.30 p.m., Ward Cases, Dr. Saunders.

Friday, 26th.—2 to 3.30 p.m., Out-patient Clinic, Dr. Gordon Holmes; 3.30 p.m., Demonstration of Fraenkel's Exercises by Mr. Elmquist.

Saturday, 27th.—9 a.m., Surgical Operations.

A Course of Practical Pathology will be given by Dr. J. G. Greenfield, if there are sufficient entries.

Fee for Post Graduate Course, £7 7s., which should be paid to the Secretary of the Hospital at the Office on entering the Course. A Special Fee of £5 5s. will be charged for the Pathological Course.

C. M. HINDS HOWELL.
Dean of Medical School.

Specialities.

A Portable Irrigator for Gonorrhœa.

As the result of objections raised that grand lavage was impracticable in private practice, especially if the patient had to travel about, the following simple and portable apparatus is now being made for me by Messrs. Down Bros. It works on the syphon principle, and consists of a metal base with rubber connections and a urethral nozzle. The sketch explains itself:—

The metal end is placed in a basin containing the antiseptic solution. The whole can be raised on a chair placed on the dressing table. A five-foot drop can thus be obtained. The whole apparatus can be carried in the pocket.

R. LEBLANC.

Pass List.

University of London.

M.S. EXAMINATION.
December, 1919.

H. B. Kent. *E. G. Slesinger.

*Awarded University Medal.

M.D. EXAMINATION.
December, 1919.

Medicine.—William S. George, B.S.
State Medicine.—R. D. Passey, B.S.

2ND EXAMINATION FOR MEDICAL DEGREES, PART II.
December, 1919.

M. Mackenzie. B. L. Laver.
A. R. V. Patel.

2ND EXAMINATION FOR MEDICAL DEGREES, PART I.
December, 1919.

C. G. Bowen. J. J. Lewinstein.
J. F. Goodenough. H. Seelenfreund.
J. Jemson. G. M. Stoker.

1ST EXAMINATION FOR MEDICAL DEGREES.

D. H. Berry. W. A. Mill.
H. G. Close. C. E. H. Moykopf.
G. D. Gross. E. E. Neser.
J. C. Hewetson. E. C. Seward.
C. Ive. W. K. Targett.
*R. E. Lane. H. D. Wyse.
F. Marsh.

*Distinguished in Biology.

Royal College of Surgeons.

FELLOWSHIP.

C. M. Ockwell, L.R.C.P.

FIRST PROFESSIONAL EXAMINATION.
December, 1919.

L. R. Broster. C. H. Medlock.
C. Lambrinudi. C. S. L. Roberts.
B. L. Laver. F. W. Widgery.

Society of Apothecaries of London.

November, 1919.

Surgery.—R. W. Warrick.
Forensic Medicine.—J. G. Barrie.
Midwifery.—J. Kendall, R. W. Warrick.

Special Constabulary—M Division.

GUY'S UNIT.

By request of the Assistant Commissioner, Scotland Yard, all cards and equipment issued to special constables during the last emergency are to be stored in bulk.

Will all gentlemen who enrolled kindly return their cards and equipment to Sub.-Inspector J. H. E. Winston, Wills Library, by Saturday the 17th inst.

T. B. LAYTON.
Chief Inspector.

Change of Address.

Capt. H. B. Wilkinson, R.A.M.C., Blackadon, Ivybridge, Devon.

Cyril Sherris, M.B., B.S., 112, Military Road, Colchester.

G. W. C. Hollist, Otley, Ipswich.

T. R. Atkinson, Avalon, Minehead, Somerset.

G. Norman Meachen, M.D., M.R.C.P., 6, Milton Avenue, Westcliff-on-Sea.

Capt. H. H. Elliot, R.A.M.C., Military Hospital, Ripon.

Capt. W. L. Gwyn Davies, R.A.M.C., Officers' Mess, Malaria Convalescent Camp, Shoreham-by-Sea, Sussex.

T. E. Holmes, M.A., M.D., Mill House, Bleasby, Notts.

Capt. G. F. Peters, R.A.M.C., Military Hospital, The Barracks, Lincoln.

G. F. Charles, 13, The Crescent, Alverstoke, Hants.

Douglas A. Mitchell, M.B., B.S., late Surg.-Lt. Com. (rtd.), The Elms, Midsomer Norton, Somerset.

H. Nisbet Eccles, 2, Headland Pk, Plymouth, Devon.

F. F. Burghard, C.B., M.S., F.R.C.S., 95, Harley Street, W.1. (Tel. Mayfair 4299).

F. J. Lidderdale, M.D., B.C., 1, Castle Hill Avenue, Folkestone.

E. S. Taylor, O.B.E., M.B., Hotel Mansions, Hong Kong, China.

H. C. Rook, 35, Ashburnham Mansions, Chelsea, S.W. 10.

H. J. Campbell, Brackley, 19, Southdown, Dartmouth.

V. R. Hirsch, The College, Guy's Hospital, S.E. 1.

Capt. W. L. E. Reynolds, D.A.D.M.S., Embarkation, Admiralty Pier, Dover.

L. Price Harris, M.C., 112a, Harley Street, W. 1. (Mayfair 213).

E. Gardner Browne, L.D.S., 23, Grange Road West, Middlesbrough, Yorks.

C. H. Kidner, 3, Lexham Gardens, Kensington, W.8.

W. A. Higgs, 12, Cloudesley Road, St. Leonard's-on-Sea, Sussex.

George S. Robertson, M.D., 72, Thurlow Park Road, Dulwich, S.E. 21.

H. T. S. Bell, Normanhurst, 100, Ben Boyd Road, Neutral Bay, Sydney.

A. R. F. Evershed, Southridge, Overbury Road. Parkstone, Dorset (winter only).

Reviews, etc.

Tuberculosis and Public Health. By H. Hyslop Thomson, M.D., D.P.H., County Medical Officer of Health, County Tuberculosis Officer and School Medical Officer, Hertfordshire. (Messrs. Longmans, Green & Co.) crown 8vo. (in the press).

The aim of this book is to present in concise form a study of tuberculosis in relation to Public Health. If the problem of tuberculosis is finally to be solved it must be viewed not merely as a disease which calls for early diagnosis and immediate treatment, but also as the indication of the existence of an inadequate hygienic and sanitary standard, which requires to be remedied.

Messrs. Longmans have in the press, for publication at an early date, a volume on the Life and Work of Sir Jagadis Chandra Bose, the founder of the Bose Research Institute in Calcutta. An account is given of his early struggles, and chapters are devoted to the records of his scientific work. It is an interesting fact that Sir J. C. Bose is the first native of India to obtain a European reputation in Physical Science. The volume has been written by Professor Patrick Geddes, formerly Professor of Botany, University College, Dundee, now of the Department of Sociology and Civics, Bombay University.

Association Football.

The following matches were played last term, and have not yet been reported in the GAZETTE:—

Oct. 18th. v. London Hospital, lost 3-7.
Oct. 25th. v. Old Westminsters, won 1-0.
Nov. 1st. v. R.A.F., Uxbridge, draw 1-1.
Nov. 5th. v. Brentwood School, won 11-0.
Nov. 15th. v. H.A.C., lost 1-3.
Nov. 22nd. v. St. Bart's. Hospital, won 8-1.
Nov. 29th. v. Middlesex Hospital, won 6-2.
Dec. 6th. v. East London College, (1st round of London University Cup), won 4-1.
Dec. 13th. v. London Hospital, lost 1-3.

A few games were also played by the 2nd XI.

A full fixture list has been arranged for both elevens, starting on January 10th, and in view of the forthcoming inter-Hospital Cup Ties, it is hoped that far greater keenness will be displayed than in the past. There is a cup for each eleven (senior and junior), and in addition there is the London University Cup and the Surrey A.F.A. Cup.

If there are any new men up, or others, who would like to play, they should lose no time in communicating with the Hon. Secretary.

Births.

GIBBINGS.—On November 12th, 1919, at Salisbury, Southern Rhodesia, the wife of R. J. Gibbings, L.D.S., R.C.S. (Eng.), of a daughter.

HANDLEY.—On December 5th, 1919, at 36, Harley Street, W., to Mr. and Mrs. Sampson Handley, a daughter.

HAMMOND-WILLIAMS.—On December 15th, 1919, at 17, Elmwood Gardens, Acton Hill, W.3., to Elsie née Barton), wife of Capt. Cecil Hammond-Williams, L.D.S., R.C.S., a daughter.

WINSTON.—On January 4th, 1920, at 90, Linthorpe Road, Middlesborough, to Mr. and Mrs. J. H. E. Winston, a son.

Marriages.

KING—JONES.—Quietly, on December 27th, 1919, at Castle Street Welsh Baptist Church, W.1., by the Rev. J. Nicholas, Frederick L. King, L.D.S., R.C.S., of Wanstead, E.11., to Nurse Mari H. L. Jones, of Newcastle, Emelyn, Wales.

ROYCE—HICKMAN.—On the 6th December, 1919, at St. Mark's, Southampton, by the Vicar, Rev. H. R. Bates, M.A., Harold, eldest son of George Appelbee Royce, of Leicester, to Katherine Louise, younger daughter of Mr. and Mrs. Frederick Hickman, late of Downshire Square, Reading.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

ON Thursday, January 29th, there will be an assembly at 4 p.m. in the Governors' Court Room, at which Sir Cooper Perry will be presented with the testimonials from the various sections of the Hospital Community. Accompanying these presents there will be an album containing an illuminated address and the signatures of all subscribers. After the ceremony tea will be served. It is hoped that all who possibly can will make a special effort to be present.

RECENTLY the Board of Education has done a great service to students who have been in the forces by giving them pecuniary assistance for the continuance of their professional studies, and there is a considerable number of men at present at the Hospital who are receiving grants from this source. But naturally the Board wishes to know that the money so spent is not being wasted, and so it requests the Dean of each School or College to report on every student to whom it is making grants. These reports are made every three months, and have to show that the men in receipt of grants are not only assiduously applying themselves to their studies, but also are capable of benefiting by their approved courses. The authorities of the Medical School are so arranging that a close touch can be kept with each man, in order to facilitate the making of these reports. This procedure is primarily intended for the benefit of ex-service students, but, as it would be obviously unfair not to treat every man equally, it will apply to all students.

We have been requested to ask all men to go up to the Medical School Office and fill up a form giving particulars of their service with the forces, if they have not already done so. If this is to count in a man's favour when he applies for appointments, it is obviously to his own advantage to comply with the wishes of the authorites in this matter.

As is well known, there is an extremely large number of students applying for admission. Unfortunately, there is not sufficient room in the laboratories for everyone seeking admission, and, therefore, all men will be expected to pass their examinations in reasonable time. If they do not, they cannot expect to be allowed to block the way of more worthy students coming after them.

IT must be understood, of course, that the authorities in no way intend to interfere with the individualism of the men. No man will

be forced to take a course of action against his will, but, at the same time, there will be no attempt at spoon-feeding in the new regime, and ignorance of his duties will excuse no one.

A MEETING of the Executive Committee of the Guy's Hospital War Memorial Fund was held on January 12th. It was decided to invest £3,000 to provide a fund for the assistance, if necessary, of the dependents of Guy's men who had fallen in the war, and for the endowment of two Scholarships, one in Arts or Science for Medical Students and one of £40 for four years for dental students.

In the second place it was decided to obtain plans for the permanent memorial to be erected in the Park at a cost of from £1,500 to £2,000.

The sum of £300 was available for the memorial decorations of the College Dining Hall, and it was decided to consult the Students' Club upon the form which this memorial should take.

THE following appointments have been made:—Mr. Ormond has become Lecturer on Ophthalmic Surgery in the place of Mr. Eason resigned; Mr. McHatton has been appointed whole-time Demonstrator of Chemistry for the remainder of the year 1919-1920; Dr. Ryle and Dr. Symonds have been appointed to take temporary duty at Medical Out-patients until March 31st, 1920, on Wednesdays and Saturdays respectively.

THE attention of all who work in the Surgery is drawn to the rule that *every* patient must be seen by the Out-patient Officer before being treated by the dresser on duty. During the war, when there was a great shortage of men, it was impossible to carry out this regulation. But as now the number of men holding appointments warrants a resumption of the usual routine of the Hospital, there is no reason why this rule should not once more be adhered to.

Now that Clinical has been revived, it is rather surprising and disappointing to find that a considerable number of most interesting cases come into the Hospital from medical out-patients without the take-in clinical being called to see them prior to admission. Consequently they come into the ordinary wards, and one hears disparaging remarks made about the Clinicals for having missed the case. The way this is done apparently is to send the case away for a few days, and then to write for it to come into the wards of the unit to whose out-patients the patient came. All those who run out-patients at present profess to be remarkably keen on the new clinical unit being a success, so that it is surprising that they should make use of this rather unsporting method of robbing the Clinicals of some of the best cases.

HIS Eminence Cardinal Bourne, Archbishop of Westminster, will preside at the third Annual Dinner of the University of London Catholic Students' Society to be held on Tuesday, February 3rd, at 7.30 p.m., in the Florance Restaurant, Rupert Street, W. The price of tickets is 7s. 6d., and all Catholic students are invited to attend. Tickets should be obtained as soon as possible from Miss Forster, 4, Queensbury Place, South Kensington, S.W.7. Mr. Hilaire Belloc and the Abbot of Caldey have also signified their intention of being present, and it is hoped that Mr. G. K. Chesterton will also be able to come.

Orbital Cellulitis.

CLINICAL LECTURE BY W. M. MOLLISON, M.Ch., F.R.C.S.

GENTLEMEN,—The title of my lecture might well lead you to think that I am invading the province of the ophthalmic surgeon. This is not so, however, because practically all cases of orbital inflammations are due to infection from the Sinuses about the nose. Until a few years since orbital cellulitis was looked upon as an idiopathic infection of the soft tissues of the orbit; the origin of this infection was not recognised and the abscesses which formed and pointed about the eyelids were opened by the ophthalmic surgeon through the eyelids. Then came the wider knowledge of the possibility of spread of infection from the accessory nasal Sinuses to the orbit through its inner and upper walls and the recognition, now universal, that all cases of orbital cellulitis are secondary to suppuration in accessory nasal Sinuses.

I have said that cases of orbital cellulitis are invariably the result of infection from the Sinuses about the nose. This is not absolutely true, because occasional cases have occurred of pyæmic orbital abscesses. I have seen one such case, a typical orbital abscess pointed in the upper eyelid; operation showed the frontal Sinus and ethmoidal cells to be normal; the patient died, and the post-mortem examination showed extensive pyæmic abscesses all over the body.

Orbital cellulitis originates as an inflammation of the bony wall of the orbit, spreading from the neighbouring Sinus. In the first place an osteomyelitis occurs; this leads to a periostitis; as in all cases of periostitis the adjacent soft tissues become inflamed. Unless operation is performed at this stage suppuration follows, pus forms under the periosteum, and in a short time in the soft tissues of the orbit.

Two stages may thus be distinguished: a pre-suppurative and a suppurative. Clinically it is far more common to see the latter; operation almost always reveals pus beneath the periosteum.

No doubt there is in every case a certain degree of osteomyelitis of the wall of the Sinus affected. Fortunately, however, it is only in a small percentage of cases that this osteomyelitis becomes a spreading osteomyelitis; when this does occur large areas of bone are affected and the prognosis is very grave.

The frontal Sinus, or the anterior ethmoidal cells, are in the majority of cases responsible for orbital cellulitis, less frequently the posterior ethmoidal cells and sphenoidal Sinus; in my experience the maxillary antrum rarely gives rise to the condition unless it be in children.

Inflammation of the soft tissues of the orbit tends to displace the eyeball, so that one of the prominent signs of orbital cellulitis is displacement of the globe.

If the abscess is in the inner and upper angle of the orbit, the displacement will be downwards and outwards. If the abscess is far back in the posterior part of the orbit, the tendency will be for it to push the eyeball forward and to cause proptosis.

Wherever the disease begins, it tends to push its way forward to the upper eyelid. The earlier stage of the cellulitis causes redness and swelling of the upper lid. You will remember that the upper lid easily swells, because of the loose subcutaneous tissue of which it is largely composed; subsequently, when the abscess has developed it points through the upper lid or about the inner canthus. If the abscess be not opened, it will burst in the ordinary way. This results in the formation of a sinus which will persist till the Sinus which caused the abscess is adequately drained into the nose.

The position of the sinus is very variable and is by no means always over the affected frontal or ethmoidal cells. It may be situated nearer the outer than the inner canthus, and it causes a good deal of puckering of the lid. I doubt if there is any exception to the statement that all sinuses about the eyelids, exclusive of wounds, are due to Sinus suppuration.

The first case of a sinus in the upper lid that came under my notice impressed the importance of this statement on me. The patient was a man with a sinus in the middle of the left upper lid; there was a slight dis-

NOTE.—In order to avoid confusion between sinus, meaning a suppurating track leading to an abscess, and Sinus, meaning one of the accessory nasal Sinuses, the former will be spelt with a small "s," the latter with a large one.

charge of pus and a probe could be passed in some distance and bone felt. It was treated as though due to some local necrosis of bone; it was vigorously scraped and packed, fomented and kept open by inserting rubber tubes. After several weeks no improvement had taken place. Mr. Symonds (now Sir Charters) then saw the case—he was then in charge of the Throat Department—as soon as he saw the sinus in the lid, without further examination he diagnosed the condition as the sequel of orbital cellulitis due to frontal Sinus suppuration. Operation on the frontal Sinus cured the patient.

War injuries have been responsible for large numbers of these cases of sinus about the eyelids. Most of the cases are those of men blinded in one or both eyes; in a great proportion there is damage to the Sinuses round the eyes, notably the frontal. I do not propose to discuss these traumatic cases further; those interested in the subject will find a full discussion in the Proceedings of the Royal Society of Medicine for 1918. That discussion made quite clear the futility of trying to cure sinuses without attacking the Sinus—antrum, frontal, or ethmoid—which was really responsible for the suppuration.

ANATOMY.

If we now turn to the anatomy of the orbit it will be clear why suppuration in the various accessory nasal Sinuses can give rise to cellulitis in the orbit and the different positions in which the cellulitis is likely to begin. Here are some sections through the head in the neighbourhood of the eye; the orbit is bounded on three sides by nasal Sinuses; below, the antrum; internally, the ethmoidal cells separated only by the thin plate of bone —the os planum; above, the frontal Sinus. Owing to its very variable size the frontal may come into close relation with the orbit only at its upper and inner angle or it may stretch from there outwards even to external angular process and backwards so far as to form a large part of the roof. At the apex of the pyramid of the orbit, rather to its inner side, is the sphenoidal Sinus. It will thus be clear that inflammation spreading from any of these spaces will easily reach the orbit.

SYMPTOMS.

Let us now consider the typical symptoms of a case of orbital cellulitis; the patient is ill, complains of headache and pain in the eye and forehead, he may have rigors or the illness may have begun with a rigor; his temperature is usually raised, in some cases it is as much as 103° or 104° F.; signs of toxæmia are also present, loss of appetite, dirty tongue, constipation. There is always a history of a cold with stuffiness in the nose or discharge from the nose; this may not, however, be volunteered as attention has been centred on the eye.

Turning to the eye symptoms and signs: the eyelids are swollen and red, the upper one much more than the lower; the globe is not always displaced, but in an advanced case it is either pushed outwards and downwards or it is pushed directly forwards—proptosis; there is often, too, a condition of chemosis-œdema of the conjunctiva. On the forehead over the "frontal Sinus area" is swelling of the tissues superficial to the bone, redness of the skin and intense tenderness to pressure. It may be possible to obtain fluctuation in this swelling or deeply through the upper lid.

Examination of the nose will reveal signs of inflammation, the mucous membrane is reddened and swollen; between the middle turbinal and the outer wall a streak of yellow pus will be seen; occasionally polypi are present. Pus may not be seen in every case, but an application of adrenalin to the turbinal will usually cause enough shrinking of the mucous membrane to allow a streak to appear; if it does not, examination with the post-nasal mirror will reveal the pus coming from the posterior nares either above or below the middle turbinal according to the Sinus supplying the pus.

DIAGNOSIS.

There are but few conditions with which orbital cellulitis can be confused: a tender swelling over the frontal area, swelling of the upper lid, pus in the nose, and the whole having an acute onset and making the patient feel ill; such a picture is pathognomonic. But it is not in every case that all the signs are found so that conditions giving rise to a tender swelling of the forehead and spreading to the upper lid can simulate true cellulitis.

Two conditions have caused difficulty in my experience: bites by insects on the forehead or eyelid, and scurvy in a child.

Some years ago, when I was Mr. Steward's assistant, a patient came to the Out-patient Department complaining of pain and swelling on the forehead. There was a considerable swelling over the left supra orbital region, very tender and exhibiting doubtful fluctuation deeply; no pus was to be seen in the nose, but nevertheless the appearance was very suggestive of inflammation in the frontal Sinus. However, Mr. Steward decided that it was an insect bite which had suppurated; an incision into the swelling released a small amount of pus, and the patient was well in two or three days.

The second condition resembled orbital cellulitis so closely that operation was performed on the frontal Sinus. The patient was a child of about three years of age; she had a red swelling over the left frontal Sinus area extending to the eyelids, the eye itself was displaced outwards; she was ill and had a considerable rise of temperature; it is true that no pus was seen in the nose, but in so young a child full examination for pus in the nose is far from easy. Orbital cellulitis was diagnosed and operation performed. On exposing the roof and inner wall of the orbit it was noticed that the periosteum stripped off easily as it does in cases of periostitis, but a layer of blood was found between the periosteum and bone. However, the frontal Sinus was opened and was found normal. Dr. Cameron kindly saw the case and found the child to be suffering from scurvy. Should the subperiosteal effusion be confined to the orbital wall it is difficelt to see how a correct diagnosis could be come to.

Other conditions that might, perhaps, lead to difficulty in diagnosis are tuberculous disease of the wall of the orbit; gummatous swellings; and growths—osteomata or sarcomata; but when we bear in mind that orbital cellulitis is at some stage an acute disease, and that the abscess progresses fairly rapidly when it has once reached the soft tissues, there ought not to be serious difficulty in distinguishing it from them.

TREATMENT.

A consideration of the pathology of the disease gives the key to the treatment: the accessory nasal Sinus that has caused the abscess must be opened externally. Since the frontal and ethmoidal are the most frequently affected Sinuses, the incision is made over the frontal Sinus, a curved incision following the inner and upper margins of the bony orbit and just below the eyebrow; the periosteum is stripped from the bone if it has not already been lifted off by pus; bone is removed till the Sinus is freely opened and the pus removed. Further details of the operation need not detain us, suffice it to say that free drainage into the nose is an essential part of the operation. Should a sinus be present as a result of the opening (surgically or spontaneously) of an abscess which pointed about the inner canthus, it is possible to drain the Sinus—probably an ethmoidal cell—into the nose sufficiently freely to allow of closure of the sinus without an external incision; this, however, is exceptional.

The following cases will illustrate the points:—

The first is that of a boy aged 12. He had swelling of the left upper eyelid and redness of the skin over the frontal Sinus with much tenderness of the forehead. On looking into the nose a steak of pus was seen in the middle meatus. The frontal Sinus was opened and pus found, but in this case no pus was found between the periosteum and the bone. This was an early case; had no operation been done pus would have soon formed in the orbit.

Next is the case of a woman of 30. She had had nasal obstruction and discharge for some time; a swelling had then appeared in the upper and inner angle of the orbit, and the eye was slightly displaced down and out. Operation here showed pus between the periosteum, and the bone and pus in the frontal Sinus and the ethmoidal cells.

The next is a case of proptosis of the right eye due to cellulitis at the back of the orbit. The patient, a boy of 11, was brought to see Mr. Eason in August, 1919. He had pain in the eye and tenderness on pressing the eye; examination of the nose revealed pus far back and cellulitis due to the posterior ethmoidal cells was diagnosed. Operation showed pus in the orbital tissues; on exposing the inner wall of the orbit a considerable destruction by suppuration in the ethmoid was found. Pus filled the ethmoidal cells. After curetting away all the ethmoid, which was extensively infiltrated with pus, the sphenoidal Sinus was also found to contain pus. Free drainage into the nose was established, and the external wound sutured. The wound healed by primary union, and the proptosis disappeared in about six weeks.

Lastly, the case of a sinus in the upper lid. Ten weeks before admission to my ward the patient, a youth of 18, had had an abscess at the inner upper angle of the left eye. This his doctor opened through the eyelid. Pus escaped, but a sinus remained, as the origin of the abscess had not been tackled. Operation was performed through the nose; a probe could be passed through from the external sinus to the ethmoidal cells and be seen in the nose. The ethmoidal cells were curetted freely, and the external sinus healed in a few days.

Fracture-Dislocations of the Ankle:

Pott's and Dupuytren's Fractures.

BY R. P. ROWLANDS, M.S., F.R.C.S.

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THESE serious accidents are so commonly followed by bad results that I venture to discuss their diagnosis and treatment, in the hope that the subject may be of interest and value to others.

A.—POTT'S FRACTURE.

There seems to be some doubt as to the exact nature of these fracture-dislocations, and it is a common mistake to regard a fracture of the lower part of the fibula without any displacement at the ankle as a Pott's fracture, whereas in reality the essence of a Pott's fracture is the dislocation at the ankle. This is clearly shown by Pott's own description, which is as follows: "A case which, according to the general manner of treating it, gives infinite pain and trouble both to the patient and to the surgeon, and very frequently ends in the lameness and disappointment of the former and the disgrace and concern of the latter. I mean the fracture of the fibula, with dislocation of the tibia."

Many of those who claim that they get good results from the conservative treatment of Pott's fracture mistake for it this simple and comparatively harmless fracture of the fibula, which gets rapidly well and leaves no permanent disability.

In a Pott's fracture the fibula is broken in the lower third, and either the internal malleolus is detached from the tibia or the internal lateral ligament is torn. These injuries allow the external malleolus to move outwards and backwards, rotating on the inferior tibio-fibular articulation. The splendid mortise made by the tibia and fibula for the reception of the astragalus is thus widened and spoilt. Instead of allowing only flexion and extension of the ankle, it now permits eversion of the astragalus and of the foot. Moreover, the astragalus not only rotates so that the outer edge of its superior articular surface is uppermost, but it is drawn backwards out of its natural contact with the lower end of the tibia by the unbalanced traction of the powerful heel tendon. Skiagraphic side views often show the posterior inferior edge of the tibia lying on the middle of the superior articular surface of the astragalus, or even on the neck of the astragalus sometimes.

B.—DUPUYTREN'S FRACTURE.

In this there are the lesions already described under Pott's fracture, and, in addition, either the inferior tibio-fibular ligaments are torn or there is a vertical fracture in the tibia just mesial to the tibio-fibular articulation. The outer and upper edge of the rotated astragalus then becomes the apex of a wedge which gradually increases the separation of the tibia and fibula when the patient stands.

The astragalus also acts as a wedge when an oblique fracture of the fibula extends upwards and outwards from just below the inferior tibio-fibular articulation. It is particularly difficult to bring this small lower fragment into its natural position, and the usual result is that a weak and unsatisfactory union occurs with the external malleolus abducted and displaced backwards. As soon as the patient walks the astragalus increases the separation (Fig. 1).

I believe that these fracture-dislocations, especially those associated with the name of Dupuytren, are some of the most serious injuries of the lower limbs, especially as they generally occur in working men in the prime of life, when they are most exposed to violent injuries. The earning capacity of a working man who has sustained one of these injuries is much depreciated. I have seen many who have not been able to work for two years from the date of the accident. Unfortunately

the abduction, eversion, and flattening of the foot, as well as limitation of movement, increase with time. If there be the slightest uncorrected abduction of the foot when the patient begins to walk, the weight of the body inevitably increases the deformity, and this is especially true of Dupuytren's fracture. Only those who watch these patients for years know how bad the ultimate results are, and how serious from an economic point of view. They come up later with rigid abducted and flat feet, seeking instrumental support or secondary operation. Osteo-arthritic changes soon take place in the ankle and metatarsal joints. Later the knee and hip may become similarly affected.

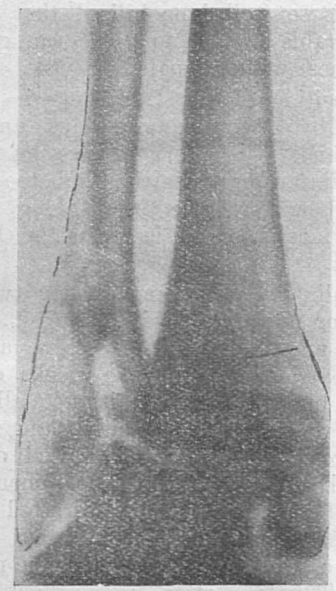

Fig. 1.—Taken a year after the fracture. The astragaloid wedge has gradually separated the external malleolus from the tibia, causing increasing deformity, serious disability and severe pain.

DIAGNOSIS.

In both Pott's and Dupuytren's fractures the foot is displaced backwards and outwards, and the heel is raised so that the foot is in the equino-valgus position. The foot is both abducted and everted, so that the toes turn outwards and the sole faces downwards and outwards (Fig. 2).

The stump of the internal malleolus is very prominent on the inner side, and may even pierce the skin. It is difficult to differentiate between Pott's and Dupuytren's fractures. A greater widening of the ankle as measured by callipers is supposed to indicate Dupuytren's fracture, but this is by no means reliable, for the external malleolus is often displaced more backwards than outwards, until the patient stands later on and brings the astragaloid wedge into full action.

As in most fractures, an X-ray examination is essential, and the ankle should be examined in two planes, so that both the lateral and the antero-posterior displacements may be seen. In this way it is possible to distinguish these two fractures, but it must be remembered that, although the inferior tibio-fibular ligaments may be torn, the astragalus need not necessarily separate the two bones until the patient stands. The separation of the

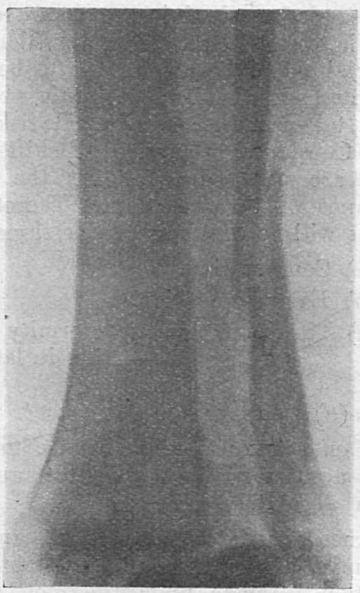

Fig. 2.—Dupuytren's fracture. The fibula is broken and separated from the tibia. The internal malleolus is broken. Note the tilting of the astragalus, and its wedge-like action.

two bones may be demonstrated by pushing the foot upwards during the X-ray examination.

TREATMENT.

The complete reduction of these fractures is admitted to be very difficult. Some years ago when, fired by Sir Arbuthnot Lane's brilliant pioneer work, I wrote a paper on this subject in the GUY'S HOSPITAL GAZETTE (February 29th, 1896, p. 118), there was some doubt upon this question, but the introduction and the improvement of skiagraphy has made

it easier to demonstrate the want of perfect apposition that exists after the most careful efforts at reduction. It is only by operation that the broken fragments can be brought into perfect apposition, and maintained in this position until bony union occurs. There are different views, however, as to the need of getting perfect apposition in all cases, for some maintain that good functional results can be obtained by careful conservative treatment, and as this method exposes the patient to no risk to life or limb, it naturally remains popular with the more conservative surgeons. My experience of the late results of the conservative treament in working men is such as to lead me to believe that early operation is necessary for obtaining a good result in them. There is no doubt, however, that operations for simple fracture are not to be lightly undertaken, and that every aseptic precaution must be taken in order to avoid risk of infection. Considerable mechanical skill and experience are also necessary for the efficient performance of the operation. Therefore the treatment will be described under three heads:

(*a*) Conservative.
(*b*) Early operation.
(*c*) The correction of deformity and restoration of function in late cases.

(*a*) *Conservative Treatment.*

Every endeavour should be made to set the fracture accurately, and for this an anæsthetic is absolutely necessary.

The knee should be well flexed, and while it is firmly held by a strong assistant powerful traction is made upon the foot, and the latter is strongly adducted and inverted while the fragments are manipulated into position. In some cases it is necessary to divide the tendo Achillis, flexion of the knee failing to afford a sufficient relaxation of this powerful tendon, which is a strong hindrance to reduction. The setting should be carried out as soon as possible after the accident, for it is much easier to get a good position before extravasation of blood and effusion into the tissues shorten the muscular and other ties around the ankle. But if the ankle is already very swollen before the patient is brought for treatment it is usually wise to wait four or five days for the swelling to subside.

Whenever possible the setting should be actually guided by the X-rays. When this is impracticable the result should be checked by subsequent screen examination.

While the foot is held in a good position at least three wide plaster bandages are applied from the knee to the toes, and the accurate position is maintained until the plaster has firmly set. When there is but little swelling it is only necessary to put a thin bandage or stocking under the plaster, but when there is much swelling, and especially if there are blebs, the limb is painted with tincture of iodine and covered with a layer of cotton wool of moderate thickness before the plaster bandage is applied. It is easier to secure and maintain a good position with a plaster splint than by any other means. Moreover, the fracture is so well immobilised that the limb is comfortable and the patient can get about on crutches without pain or risk.

The position of the fragments is later ascertained by screen examinations, and if the setting is not satisfactory it must be repeated. If the splint compresses the limb too much it can be opened up the front along a rubber tube previously placed between the limb and the splint.

The splint is not removed for twenty-one days; after that time it is taken off daily for massage, movement and exercises, and it is finally abandoned about five weeks after the accident, but the patient is not allowed to stand or walk for two months, and then the inner border of his boot is raised a quarter of an inch to prevent the development of abduction of the foot from ill-directed strain at the line of fracture while the bones are soft. For bad cases an external steel support, with a strong T valgus strap, is supplied for nine months after the accident.

(*b*) *Early Operation.*

When a good position cannot be obtained by the method already described and the patient is healthy and active, there are no contraindications to an operation, and the services of a good and aseptic surgeon experienced in the operative treatment of fractures can be obtained, early operation, say within a week of the accident, is strongly indicated, for it offers a very good chance of a perfect limb.

A tourniquet is applied around the thigh after the limb has been elevated for a few minutes and all the skin below the knee has been most carefully sterilised. A slightly curved incision is made over the lower third

of the fibula, starting over this bone at its lower point of trisection and extending slightly forwards and terminating one inch below the tip of the external malleolus. All the soft parts, down to the periosteum, are then reflected backwards. This flap method is better than a straight incision over the line of fracture.

Sterilised pads are accurately secured over the edges of the wound with tissue forceps so that no skin is left exposed. The ends of the fragments are isolated partly with the knife and partly with broad elevators and levers. They are then brought into perfect apposition by means of Lane's long-handled forceps and fixed in position by a steel plate

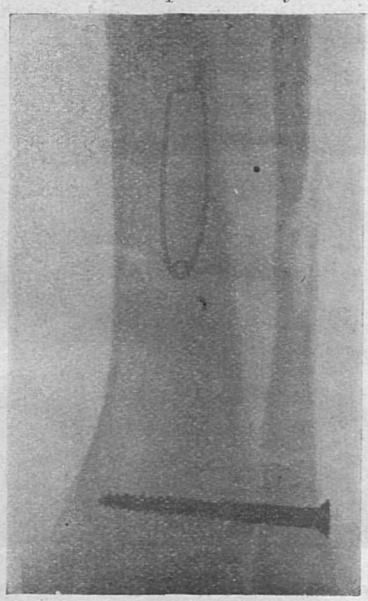

Fig 3.—Taken a week later. The contiguous surfaces of the tibia and fibula have been pared and a long screw has been inserted to keep the bones together. Note the apposition of the fibular fracture and the adduction of the internal malleolus. The man has walked many miles as a commercial traveller for nine years, and still retains the screw and perfect use of the leg and ankle.

or circumferential wire. In all cases the inferior tibio-fibular joint is exposed near the lower angle of the wound, and if there is separation of the two bones at this point, indicating Dupuytren's fracture, the simplest and most satisfactory way of correcting the deformity is to chisel away the cartilage from the contiguous surfaces of the two bones, and then pass a long screw obliquely inwards and slightly upwards through the fibula and tibia a little above the ankle joint (Fig. 3). Fig. 4 shows the failure of a plate and the need of the long screw. A screw passed in a similar way is very effective for those common cases of oblique fracture extending upwards and outwards through the fibula and just below the inferior tibio-fibular joint (Fig. 7). This and the preceding fracture give very bad results with conservative treatment, for the upper and outer edge of the displaced astragalus acts as the apex of a powerful wedge which gradually and certainly increases the separation of the bones at the site of injury. In many cases this is all that is required, for as the screw is driven home the fibular fragments become locked in good position. When this is

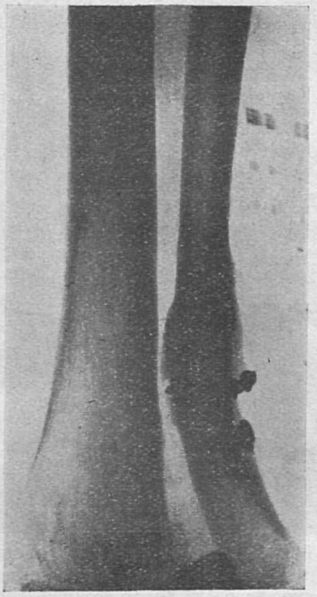

Fig. 4.—This picture shows why plating the fibula is insufficient treatment for Dupuytren's fracture. The astragaloid wedge still acts as a powerful abductor of the external malleolus, widening the important malleolar mortise, making the ankle insecure and causing osteo-arthritis with a painful abducted and everted foot.

not so a plate is fixed over the outer surface of the fibula at the site of fracture, which is generally about two inches above the malleolus. When the fracture of the fibula is oblique or spiral a circumferential wire is often simpler and more efficient than a plate.

The internal malleolus, when broken, rarely needs to be exposed, for the replacement of the external malleolus and astragalus generally forces it into a good position. Through-

out the operation the greatest care is taken to maintain asepsis, in order to obtain a perfect result. The wound is then closed with a continuous salmon-gut suture, and a massive dressing is firmly applied before the tourniquet is removed. The tourniquet allows far speedier, gentler, and more accurate work, and the application of the massive firm dressing before its removal prevents extravasation of blood into the tissues. A comfortable back splint is applied and the leg is slung in a Salter's cradle. The long screw has not given rise to any trouble, and in some cases it has been retained for many years.

Fig. 5.—This shows a lateral view of a Dupuytren's fracture three months after the accident. Several attempts have been made to reduce the deformity. Note the displacement of the astragalus (and foot generally) backwards, and the talipes equinus. Abduction and eversion of the foot were also severe.

(c) *The Correction of Deformity and Restoration of Function in late Cases.*

An attempt to restore the broken fragments to their natural position is not likely to be successful later than three months after the accident. An operation for this purpose may be very formidable, difficult, and somewhat dangerous, for a good deal of callus has formed, matting and shortening of the soft parts have occurred, and above all the fragments themselves have atrophied and become soft so that they do not hold a plate or screw easily (Figs. 5 and 6).

In these cases it is far better to do all we can to obtain a movable ankle without equinus and to restore the proper alignment of the limb. These objects can be attained and a very useful limb secured with ease and safety as follows :—

When the patient is under the anæsthetic and the limb has been carefully sterilised, the knee is bent and held by an assistant while the surgeon grasps the fore part of the foot and moves the ankle freely. When flexion is considerably limited it is wise to divide the tendo Achillis subcutaneously. Stronger union is obtained in the tendon if its two lateral halves

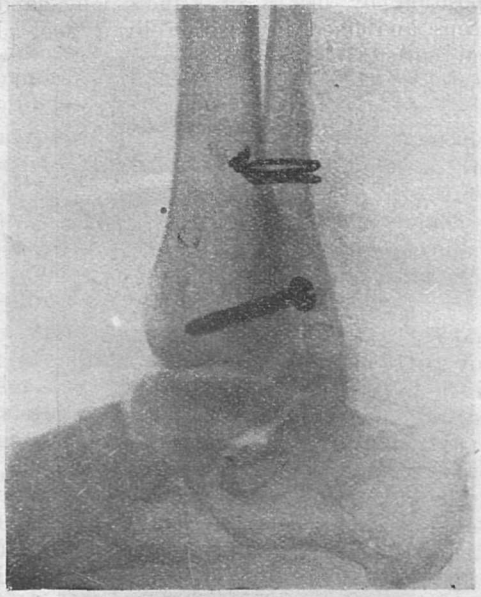

Fig. 6.—From the same leg as Fig. 5. Some of the body of the astragalus below the upper articular cartilage had to be removed before the reduction could be done. The screw and circumferential wire secured the bones in good apposition. The function of the ankle was much improved, and its shape excellent. The screw and wire have given no trouble and have been retained for eight years.

are divided at two different levels about an inch and a half apart. When good movement has been obtained the limb is turned on its outer edge on a sand pillow, and a small longitudinal incision is made with its centre one inch above the tip of the internal malleolus. An osteotome is then driven transversely outwards across the bone three-quarters of an inch above the level of the tip of the malleolus. At this level there is no fear of entering the ankle joint. As far as possible the work is done subperiosteally.

When the bone is almost completely divided an attempt is made to snap the remainder and to bring the foot into a good position. If this fails the osteotome is reinserted, and, if necessary, driven on to notch or divide the fibula.

The deformity is slightly over-corrected, the wound closed with catgut, and the limb secured in a good position with plaster bandages over an antiseptic dressing. The after-treatment is similar to that already described under conservative treatment. The functional results obtained in this safe and simple way are very gratifying (Figs. 9 and 10).

CASE 1.

A commercial traveller, aged 30, alcoholic and stout; admitted into the Accident Ward on

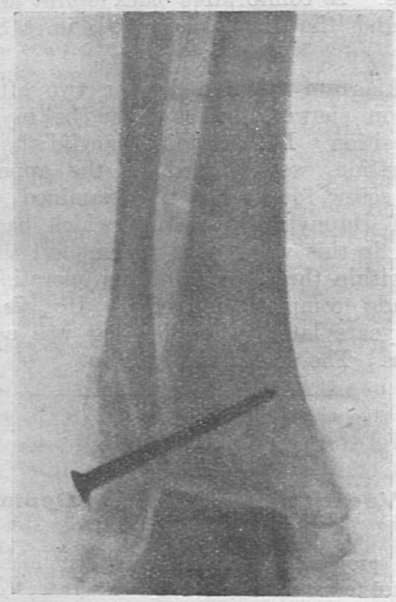

Fig. 7.—A fracture just like that shown in Fig. 1. Here the screw passed obliquely upwards, forwards, and inwards, secured accurate apposition and a perfect ankle. The screw caused no trouble, and has been retained for eight years.

December 15th, 1910, having sustained a Dupuytren's fracture of the left ankle. Endeavours were made to replace the bones in position without avail. A skiagram taken after these endeavours showed the presence of Dupuytren's fracture with considerable separation between the tibia and fibula, and the outer upper edge of the astragalus was acting as a wedge separating the two bones (Fig. 2). The internal malleolus was broken. In spite of the fact that the man was alcoholic, an operation was advised and performed two days after the accident.

Every care was taken to sterilise the skin. The patient took a great deal of anæsthetic, and was riotous under it. A broad, flat tourniquet was applied just below the knee. Endeavours were made to correct the deformity by traction and manipulation. The tendo Achillis was divided subcutaneously. A long curved incision was made in front of the lower end of the fibula. The broad flap thus made was separated from the fibular periosteum and drawn backwards. The skin was entirely covered by gauze pads, which were carefully secured to the subcutaneous edges of the wound by means of tissue forceps. The peroneus

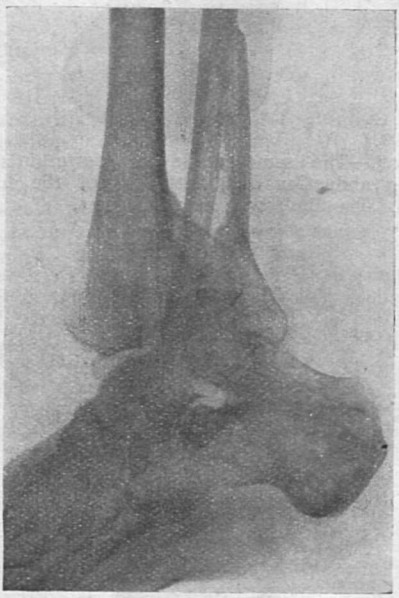

Fig. 8.—Showing a severe Pott's fracture eighteen months after the accident. The foot was almost useless. Note the deformities. The same ankle is shown in Figs. 9 and 10 before and after operation.

brevis, being the most powerful abductor of the foot, was sought and divided. The outer part of the lower end of the tibia was defined, its inferior and external articular surfaces being well displayed. Much dark blood and clot escaped from the ankle-joint. The traction and adduction of the foot were made while the lower end of the leg was drawn outwards. These manipulations failed to bring the fibula into its natural position, and it was necessary to use an elevator to prise it out at

the site of fracture, and to apply a long-handled Lane forceps to the lower fragment,

Fig. 9.—The same ankle as shown in Fig. 8. Showing abduction and flattening of the foot with equinus. The limb was nearly useless.

Fig. 10.—The ankle shown in Figs. 8 and 9 eight months after tenotomy of the tendo Achillis with osteotomy of the tibia and fibula through a small incision one inch above the tip of the internal malleolus. The function of the limb was good, the patient being able to walk long distances without pain, and move the ankle well.

in order to bring this into its natural relationship with the lower end of the tibia. The surfaces of contact between the tibia and fibula were pared. Then, while a good position was maintained, a long steel screw was driven horizontally through the lower ends of the fibula and tibia about half an inch above the lower articular surface of the latter. The fracture in the fibula, which was about three inches up, was thus brought into a good position. Plating at the site of fracture was seen to be unnecessary (Fig. 3). Moreover, the foot was brought into a good position, and the internal malleolus was also approximated to its original position on the lower end of the tibia. The deep fascia was sewn with catgut and the skin with fishing gut. The wound was dressed and firmly bandaged before the tourniquet was removed. The operation lasted about twenty minutes. A comfortable back splint was applied and the limb suspended in a Salter's cradle.

A skiagram taken a day or two after the operation showed the bones to be in a perfect position. Dr. Morton, who did the X-ray examination, was puzzled by the appearance of the screw, for he had not examined another case of Dupuytren's fracture which had been treated in this way. The patient left the hospital within three weeks of the operation, and he made complete recovery. He was seen seven years later, when his leg was as good as ever. The screw was still in.

Notice.

Vacancies for Assistant Dental Anæsthetists.

It is proposed to appoint Assistant Anæsthetists to administer anæsthetics on the afternoons of Mondays, Tuesdays, Thursdays and Fridays.

The honorarium for one attendance per week will be threequarters of a Share in the Dental School Fund, with a minimum of £25 per annum.

Candidates should say whether they are prepared to attend on more than one afternoon in the week, and applications should be sent to the Treasurer at the Superintendent's Office not later than Saturday, the 24th instant.

January 13th, 1920.

WE would draw attention to the fact that in our last issue, on page 14 of the advertisement section, an error was made in the name at foot of the advertisement of "Tonalka," the British Tonic Aperient Water. The name should read:—Idris & Co., Ltd., Camden Town, London, N.W. 1.

Leaves from a Medical Note Book

(1914–1918).

XI. Wounds of Heart and Aorta not immediately Fatal.

Recoverable wounds of the heart are no longer rarities. The following case did not recover, and is only remarkable in that a wound so severe did not cause death for forty-eight hours.

Private A. was admitted with a large ragged wound in the right side of the chest, fracturing a rib and causing much distress and pain. There was vomiting, and patient was very collapsed. Over the præcordial area there were audible loud metallic friction sounds suggesting two fragments of metal in contact. The entrance wound was temporarily stitched to control oozing and entry of air. At autopsy there was no fragment within the pericardium, but the missile was found to have ploughed a track through the right lung and made an open hole in the pericardium and right auricle. There was no large effusion of blood, but septic pericarditis was already established. The curious friction sounds were not explained.

In a second case, which also survived for forty-eight hours, the entry was low down in the posterior axillary line on the right. There was pain in the loin, but no evidence of an intra-abdominal lesion. There was a history of hæmoptysis, the wound had oozed considerably, and the patient was very pale. Great difficulty was experienced in controlling the hæmorrhage; stitching the wound, which is usually successful in cases of leaking hæmothorax, was unavailing, and the liver was presumed to be damaged.

At autopsy, however, it was found that in addition to perforation of the right lung and œsophagus there was a slit in the aorta which had started to seal itself by thrombus formation. The hæmothorax was already infected.

Small wounds of the heart and pericardium with lodgment of tiny fragments seemed to cause very little trouble.

(To be continued.)

Appointments.

Medical School Appointments

16TH JANUARY—15TH APRIL, 1920.

Preliminary Clinical Appointment.—Messrs. I. J. Bechal, H. B. Flooks, H. A. H. Harris, M, M. Hegab, B. L. Laver, M. Mackenzie, H. Richards, H. K. Wallace, F. W. Widgery.

Clerks to Medical Unit (first three months).—(Dr. Fawcett and Dr. Cameron) Messrs. H. O. Eksteen, M. A. El-Biblawi, M. H. MacKeith, J. K. Milward; (Dr. Beddard and Dr. Hunt) Messrs. A. H. Douthwaite, T. E. Jones, C. Shepherd; (Dr. French and Dr. Poulton) Messrs D. Davies, T. J. Lane, A. T. Rogers; (Dr. Hurst and Dr. Mutch) the Clinical Assistants.

(Second three months).—(Dr. Fawcett and Dr. Cameron) Messrs. J. Herbert, G. B. Kirkland.; (Dr. Beddard and Dr. Hunt) Messrs. H. W. Harvey, C. M. Short, A. E. Strawbaun; (Dr. French and Dr. Poulton) Messrs. M. T. Ahmed, G. C. W. Curson, B. Kessel, E. Hardy; (Dr. Hurst and Dr. Mutch) the Clinical Assistants.

Dressers to Surgical Unit (first three months).—(Sir Alfred Fripp and Mr. Turner) Mr. E. H. Richards; (Mr. Steward and Mr. Hughes) Mr. R. J. Hodgkinson; (Mr. Fagge and Mr. Davies-Colley) Mr. H. W. Taylor; (Mr. Rowlands and Mr. Bromley) Mr. M. E. Shaw.

(Second three months).—(Sir Alfred Fripp and Mr. Turner) Messrs. J. N. Alexander, G. E. W. Felce, T. B. McCann; (Mr. Steward and Mr. Hughes) Messrs. F. Bekker, G. W. Elkington, L. K. Watson; (Mr. Fagge and Mr. Davies-Colley) Messrs. J. B. Gregor, L. R. A. Wells; (Mr. Rowlands and Mr. Bromley) Messrs. S. Annecke, F. L. Rayner, A. H. Shelswell.

Clerks in Department for Children.—

A. *With Dermatology.*—Messrs. I. W. Arnovitch, M. Hall, J. T. Jones, P. L. Richardson, J. Sullaiman, R. E. Williams.

B. *With Neurology.*—Messrs. P. Caucaud, O. T. Maclaren, R. M. Patterson, W. Remington, I. Rosenberg, T. W. Turner.

Obstetric Dressers and Externs.—(Mr. Bellingham Smith) Messrs. C. I. C. Gill, W. D. Doherty, A. McKenzie, M. Maizels, A. Mikhail; (Mr. Chapple) Messrs. K. J. H. Davies, J. H. Burn, W. H. Summerskill E. J. Crisp.

Assistants to the Pathologists to the Hospital.—Messrs. W. M. Brown and G. W. Elkington.

Student Demonstrator of Microscopical Pathology.—Mr. E. F. Wilson.

Clerks or Dressers in Special Departments—

Opthalmology (Mr. Ormond) *and Dermatology.*—Mr. J. J. F. Rooney.

Opthalmology (Mr. Ormond) *and Laryngology* (Mr. Mollison).—Mr. E. E. D. Gray.

Laryngology (Mr. Mollison).—Mr. E. F. Wilson.

Opthalmology (Mr. Eason).—Messrs. R. M. Patterson, W. Remington, F. W. Crook.

Genito-Urinary and Laryngology (Mr. Layton).—Mr. G. V. Richards.

Dermatology.—Mr. E. J. Crisp.

Neurology.—Mr. D. Maximos,

Orthopædics.—Mr. L. Burvill-Holmes.

Venereal Diseases.—Mr. M. Sidky.

Clinical Assistants.—Messrs. M. Coburn, G. Massie, H. N. Schapiro, S. T. Barrett, and L. Moss.

Clinical Assistant in Medical Wards (to Dr. French).—Mr. J. W. Featherstone.

Student Demonstrators of Anatomy.—Messrs. H. B. Jones and R. Brooke.

Guy's Hospital.

In accordance with annual custom the House-Committee pulishes for the information of the Medical, Surgical, and Nursing Staff the following Tables showing the total number of Patients sent during the past year to Convalescent Homes and Sanatoria.

WARDS.	NUMBER OF PATIENTS. 1918	1919
Astley Cooper	8	8
Cornelius	11	9
Lazarus	37	35
Job	22	18
Naaman	14	29
Luke	26	37
Evelyn	16	15
Patience and Samaritan	9	9
Charity	61	55
Dorcas	45	34
Lydia	31	43
Martha	22	24
Eye Wards	12	9
Addison	31	35
Mary	15	30
Stephen	—	23
Esther	30	15
Queen Victoria	14	20
Clinical	23	—
Out-Patients Department ...	120	136
	547	584

The subjoined list gives the distribution of the Patients amongst the various Homes:—

Ascot Priory (Women and Children)		88
Merchant Taylors' Home (Bognor) (Men) ...		26
Metropolitan Convalescent Institution:—		
Bexhill (Women)	102	
Bexhill (Little Common) (Men)	45	
Broadstairs (Children)	78	
Walton on Thames (Men & Women)	28	
		253
Rustington Convalescent Home		48
Schiff Homes of Recovery		47
		462

SANATORIA.

(Beds allocated free of charge to the Hospital by the King's Fund):—	
Devon and Cornwall Sanatorium	12
Kelling Sanatorium, Holt, Norfolk	7
Holt Sanatorium (Children)	3
	484

In addition to the above, 100 Patients have been sent to various places for convalescent treatment, principally in co-operation with the Charity Organisation Society, and the Invalid Children's Aid Association 100

584

List of amounts received from Patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1919. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1919 £ s. d.	Special Donations. 1919 £ s. d.	Total for 1918 £ s. d.
Front Gate Box ...	5 4 11	—	5 18 5
Porter's Lodge ...	12 7 8	—	9 16 0
Out-Patient Dept.	47 11 4	11 0 0	44 18 1
Surgery	27 7 11	—	20 4 3
Dental Department	2 16 0	10 0	3 11 3
Light Department	14 8 11	22 1 6	26 5 3
Massage Dept. ... (Treatments)	116 13 3	3 1 0	77 12 2
Electrical Dept....	14 16 1	—	15 13 9
	WARDS.		
Addison	1 1 10	46 1 0	30 12 0
Astley Cooper ...	2 1 10	25 18 0	47 4 2
Bright	18 6	130 15 0	16 2 11
Charity	5 12 1	74 0 0	63 11 6
Clinical	1 11 7	—	17 9 10
Cornelius	2 3 6	19 14 0	16 1 7
Dorcas	13 12 7	65 19 6	147 11 5
Esther	2 6 9	78 4 0	54 7 9
Evelyn	2 11 4	9 5 0	40 5 0
Eye	9 11 9	17 11 0	31 8 2
Job	8 8 10	51 6 5	43 16 10
Lazarus	1 10 8	42 18 0	43 2 0
Luke	4 18 3	38 4 0	29 18 6
Lydia	5 14 8	90 14 6	58 18 8
Martha	9 8 0	77 11 0	158 4 9
Mary	2 5 6	42 8 0	44 17 2
Naaman	2 5 9	79 0 6	39 1 0
Patience and Samaritan ...	2 19 11	5 5 0	8 13 7
Queen and Victoria ...	14 3 4	88 6 6	100 19 4
Stephen	9 19 0	53 11 0	38 18 1
	£344 11 9	1076 4 11	1235 3 5

	1919.	1918.
Box Collections	344 11 9	264 1 11
Special Donations	1076 4 11	971 1 6
	£1420 16 8	£1235 3 5

In addition to the above, the following sums have been received from Patients in respect of Special Treatments during 1919:—

Light Department ...	98 14 3
Massage Department ...	52 11 6

Reviews, etc.

Ground-Work in Surgery. By Arthur Cooke, M.A., M.B., B.Ch. (Oxon.), M.A. (Cantab.), F.R.C.S. (Messrs. W. Heffer & Sons), pp. 183, price 7s. 6d.

This small work supplies a long-felt need by the prospective student of surgery, namely, a logical introduction to the subject, indicating to him the broad principles in which his mind should work in approaching any given case and giving him a basis on which to found the subject of surgery with the clinical material at his disposal. How often one finds the average student at the end of his first six months' study of surgery wallowing in a maze of local lesions and signs, but totally forgetful of the broad principles underlying every case. This book should be read by all commencing surgery, and by those holding dresserships. Our chief criticism of the book is the small space allotted to growths compared with that allowed for injuries and congenital abnormalities.

The Story of English Public Health. By Sir Malcolm Morris, K.C.V.O. (English Public Health Series, Messrs. Cassell & Co.), pp. 166, price 5s. net.

The subject of public health is one to which the medical student at present pays a minimum amount of attention, partly because of the attitude of many examining bodies, partly because both lectures and text books on the subject have a reputation for intrinsic dulness. Sir George Newman in his report on medical education very rightly says that this attitude cannot continue, and this little book may well mark the dawn of a new period in the study of the subject. The book is written as an introduction to a series on food, housing and welfare of mothers and infants, intended primarily for lay readers such as members of local authorities, district nurses, health visitors and voluntary workers, but medical students will find it both interesting and instuctive, and those working for the diploma of public health examinations will find that, as an introduction, the historical account here given will add interest and purpose to the dry bones of sanitary law. The earlier chapters are historical. They begin with Richard Mead's "Short Discourse concerning pestilential contagion," published in 1720, and lead up through the pioneer work of Edward Chadwick, Sir John Simon, and others, and the various public health Acts and changes in administration to an account of the public health service as it existed before the establishment of the Ministry of Health, in which no less than twenty central authorities and innumerable local authorities were concerned. Of the concluding chapters one is devoted to a brief but illuminating account of the problems of infection and immunity, another to an account of the crusade against venereal disease, and the final chapter to the changes in the direction of simplification and increased efficiency which may be expected through the establishment of the Ministry of Health, in which for the first time a medical man is given the status of permanent secretary.

Football.

RUGBY.

GUY'S v. ROSSLYN PARK.

This match was played on the Hospital Ground on January 3rd. Graham Davies could not turn out because of his damaged leg, J. Krige was at Twickenham in the trial, and Marais and Reitz were both away. All this necessitated re-arrangement, and when the sides lined up Van Schalkwijk was seen in the centre with P. Krige, E. L. Sprong stood off to Bekker, and A. Daneel was on the left wing. Splendidly P. Krige got into his stride; it was his first appearance since his injury on November 8th. About ten minutes from the start Steyn sent over a wide pass to Van Schalkwijk, who presented Daneel with an unopposed run to the posts. The former converted. Steyn with Krige's assistance got the next try. Shellswell then made a gallant attempt to score from Bekker's pass. Immediately after Krige sent Steyn an almost subterranean pass which the wingman fielded in marvellous fashion and raced behind with. Inter-passing between this wing again took place. Krige received from Steyn, and when on the line was tackled, and had the misfortune to dislocate his shoulder. Wretched bad luck for Guy's and for so plucky a player. Krige is keenness itself on the game, and always anxious to do his utmost for the Hospital's reputation in the Rugby world. May his recovery be speedy and complete!

Changing ends, we were a little lost with Steyn in the centre and Watson on the wing. Doherty, playing his fourth game in a week (Guy's men please notice), led his men with great dash. Van Schalkwijk got Daneel going several times, and at length the wingman crossed. Van Zijl also scored, and later Steyn went over full steam for a grand score. There was a time during the second half when the Park played quite well, but they missed opportunity and our defence is sound. Daneel and Sprong both tackled well. The latter must try and discriminate more between when to hold and when to pass. At present he holds too long. Van Zijl and Neser played well. Olivier was excellent at full back. With so much forward talent one would almost like to see Reitz as a three-quarter. Could it be tried once? Guy's, 1 goal, 5 tries; Rosslyn Park, nil. Guy's team:—

W. Olivier, G. L. Steyn, P. Krige, G. Van Schalkwijk, A. Daneel, F. Bekker, E. L. Sprong, W. D. Doherty, A. H. Shellswell, G. R. Aspinwall, L. K. Watson, G. Zondagh, A. Van Zijl, A. Peauw, B. L. Laver.

GUY'S v. OLD MERCHANT TAYLORS.

Congratulations to J. Krige on getting chosen for England v. Wales on January 17th. But what about Millett if Krige had not been chosen. One felt inclined to repeat a saying of not many years ago, "Once a Guy's man always a reserve." Millett has our sympathy. He is, and I hope all our readers are, too good sportsmen to grouse, but shades of P. F. McEvedy, A. B. O'Brien, L. B. Stringer, C. S. L. Roberts, and, no doubt, others can be remembered, who have figured in many trials until their form must have been as an open book, yet the choice

of the Selectors has been on 15 other men. Graham Davies has a leg injury. Bad luck! He stood a very good chance of a Welsh Cap, in fact, on recovery he may even get one yet for one of the later matches.

What about the above match. That duty must be my immediate concern. The first half we had the wind behind us, and by some excellent work on the part of our backs, who all handled well, Van Schalkwijk, coming up again on Williams' right, scored a capital try. Bekker and Sprong then got Steyn going for a splendid score, Van Schalkwijk converting from an awkward angle. It was good to see the newer men, Daneel, Williams and Sprong, figuring well. Sprong was quite useful, still apt to hold too long, and one hopes he will not do too much subterranean work. Bekker will scramble through about 15 men if it is possible; he enjoys it. Sprong should let the ball out as much as he can. Van Schalkwijk did wonderfully well as a centre, it is by far his most natural position. Steyn, too, was in top form. Bekker was, well, simply Bekker; that is, untiring, unselfish and very clever. Before half time Neser got in, and again Van Schalkwijk cleverly goaled.

We had the force of a hurricane in our faces for the second half, and a torrent of rain. How our men stuck it so well can only be explained by their condition. The Taylors gave us plenty to do for 20 minutes, and only hard tackling by Olivier, Sprong, Bekker and Daneel kept our line free. At length, however, we had to submit to a try against us. Hodson got it, and deserved it. The Taylors had played with steam at full pressure. Our forwards did not like the mud. Doherty, Neser, Reitz and Shellswell were all right, but why keep picking at the muddy leather. Hard, close dribbling was the game. Watson wants a little more weight, but he lasted well. Zondagh pushes, but he wanders in the loose. Peauw and Van Zijl were not so good as the previous Saturday. But the elements were the "divil" for these forwards. Too much criticism on such a day is scarcely fair. Grand work by the backs, Steyn, Williams, and Van Schalkwijk, and both halves and one try from Steyn. A grand conversion by Neser, and the game ended: Guy's, 3 goals, 1 try, 18; Old Merchant Taylors, 1 try, 3. Guy's team:

W. Oilivier, H. K. Williams, G. L. Steyn, G. Van Schalkwijk, A. Daneel, F. Bekker, E. L. Sprong, W. D. Doherty, F. W. Reitz, A. H. Shellswell, E. E. Neser, A. Zondagh, L. K. Watson, A. Van Zijl, A. Peauw.

GUY'S v. UNITED SERVICES.

The other day some contemporaries were bemoaning the fact that Guy's were not the side they were. After Saturday, when Doherty, P. J. Krige and J. A. Krige, Shellswell and Graham-Davies were out of the side, they must perforce conclude that Guy's are better than ever. The Services, with quite a good side, were beaten by no less than 20 points to nil, 1 goal and 5 tries to nothing. It is a pity the goal kicking was not better. But it should be noted that only by a small margin did Neser miss his first two attempts. Guy's forwards were splendid. It is difficult to single out those who did best when all played so well. Marais and Van Zijl I would, however, specially commend. The first try was well gained by Bekker after good forward work. The second was gained by Daneel after Van Schalkwijk had given him a chance or two. Daneel did quite well, but once or twice he slowed up and looked round for help when in possession: so did Williams on the other wing. The inside pass comes off sometimes, but a wingman should go for the line. If his partner is up and lets his outside know it, that is a different story. Quite good was Sprong's try, and so was Neser's conversion.

After half-time, Bekker, who performed splendidly throughout, threw the ball constantly to Sprong. It is a pity the latter does not discriminate more when to pass and when to busy himself. His defence, however, and tackling were splendid, and the heavy work found Sprong thoroughly enjoying himself. A great rush by the Navy was brought up by Olivier, and soon the forwards had the ball back. Finely Williams came out and tackled the opposing back. The scrum that followed found Steyn in possession from Bekker and Van Schalkwijk, a magnificent run ending with a try. Daneel, tucked up by the corner flag, passed in cleverly for Marais to gain a try, and before the end Steyn scored again brilliantly, this time from an inside pass from Williams. None of these tries were converted. Olivier improves with every game. All the backs did splendidly, and certainly Williams and Daneel have every reason to be pleased with their performance in the 1st XV. The tries were all cleverly obtained, and the passing throughout a hard game never fell from the high standard of the best Rugby football.

Guy's must now train hard for the Cup Ties. Any man with a chance of being in either the first or second XV. should make himself as fit as possible. The best possible physical condition of our players is the safest road to the Hospital Cup. Cup games are very hard games, and the victory goes to the best trained side.

A great crowd witnessed the above match at Honor Oak Park, and among many prominent Hospital supporters were Mr. Steward and Mr. Fagge.

Guy's team:—

W. Olivier, H. K. Williams, G. L. Steyn, J. Van Schalkwijk, A. Daneel, F. Bekker, E. L. Sprong, F. W. Reitz, A. Marais, L. K. Watson, G. E. Kidman, H. Van Zijl, E. E. Neser, A. Peauw, and R. R. F. Duncan.

The Hospital have up to this date scored 354 points to 29. Their line only crossed 7 times, and in two matches only have they been beaten. These two matches are the only ones in which double figures have not accrued to the XV.

ASSOCIATION.

GUY S v. OLD ALDENHAMIANS.

Played at Honor Oak Park on January 3rd. Unfortunately for this match, Guy's were without their regular halves, though the score hardly represents the even nature of the game. Before the interval, with the wind in their favour, the Guy's forwards had most of the play, but their shooting was ineffective. In the second half, with one goal in their favour, the Old Aldenhamians played together well, and quickly added two more goals. Coxon scored one for Guy's, but just before time the Old Boys added another. Thus Guy's lost by 4 goals to 1.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Court Room was crowded on Thursday week when the late Superintendent was presented with the various testimonials from his friends at the Hospital. Every section of the Hospital community was well represented—Sisters, Nurses, Administrative Staff, Consultants, Present Members of the Staff, Residents, Students—composed the throng which had gathered to show their respect and gratitude to Sir Cooper Perry. Dr. Fawcett then opened proceedings by introducing Dr. Shaw, and the latter, addressing his old friend, voiced the feelings of all present in a charming speech, delivered in his own inimitable manner. The Senior Physician then formally made the presentation, particulars of which are printed elsewhere in this issue, together with the speeches of Dr. Lauriston Shaw and Sir Cooper Perry.

The proceedings were concluded by three hearty cheers for the "Super," and Sir Cooper withdrew to the chorus of "He's a jolly good fellow."

WE regret to announce that we are unable to present our readers with a portrait of Sir Cooper with this issue. However, we hope to remedy this fault in a forthcoming number of the GAZETTE.

WE may also mention that the Committee appointed to make arrangements for a Presentation on the occasion of Sir Cooper Perry's resignation of the post of Superintendent, passed a resolution that the Governors' and Staff Dinner be revived at an early date, and that Sir Cooper be the guest of the evening.

THE scheme recently adopted by the House Committee, by which House Appointments begin and end in the middle of the month, has already proved extremely popular with everyone. By this means the House Officer elect will be able to have a fortnight's hard-earned holiday after his strenuous, if instructive, three months as Out-Patient Officer.

WE have received the January report of the Research Defence Society. This Society, now just twelve years old, has proved a blessing, not only to the medical profession, but also to the whole community. When it was founded the anti-vivisectionists were flourishing, and

constituted quite a grave menace to pathological and therapeutical research, but now, thanks to this body, one hears but little of their activities. True, we have occasionally received amusing little booklets from them, telling us that it had been definitely proved that there was no such disease as hydrophobia, and that it was very wrong to submit dogs to the terrible torments of muzzle-wearing, that Pasteur was a charlatan, and so on, but we did not take them very seriously, and we doubt if anyone else with an appreciable amount of grey matter has done so. And so we may congratulate the Society on having performed a great service to humanity. But there is still a lot of work for them to do. For instance, there are still a fair number of misguided individuals who have a "conscientious" objection to being vaccinated, and who, during a small-pox epidemic put their own and their children's lives in jeopardy by refusing this gracious gift of acquired immunity. May we hope that before long the Research Defence Society will have brought about a revision of the laws relating to Vaccination, and so save hundreds of lives in the next severe epidemic of Variola.

The January number of the *Prescriber* is well worth purchasing, comprising, as it does, a remarkably complete and compact summary of new treatment for 1919. Nearly forty different subjects are dealt with in this booklet, which should prove most useful to those who have neither time nor inclination to search for jewels in the mine of current medical literature.

We are pleased to learn that Miss L. B. Hutton, late Assistant Matron, has now taken over, from February 5th, Dorset House Nursing Home, 25, Dorset Square, N.W. 1 (Telephone, Paddington 369), assisted by Miss N. J. Maher, late Sister Bright. Dorset House Nursing Home has always been associated with Guy's, and we therefore wish the new management every success in the work they are about to take up in the West End. We feel sure they will receive the full patronage of the Guy's Staff.

Presentation to Sir Cooper Perry.

The presentation to Sir Cooper Perry on his resignation of the office of Superintendent was made on Thursday, January 29th, in the Governors' Court Room, which was filled to the limit of its capacity by a gathering representative of every section of the Hospital.

Dr. Fawcett, senior Physician, occupied the Chair, and on the platform were Sir Cooper Perry, with Lady Perry and Miss Perry, and Dr. Lauriston Shaw.

The Chairman introduced Dr. Shaw, as Sir Cooper's oldest friend and colleague, who spoke as follows:—

Sir Cooper Perry,—Forgive me if I first thank this assembly of your fellow-workers at Guy's for entrusting to me an agreeable—if somewhat difficult—task. For I have been asked to act as their spokesman this afternoon, and now I must tell you on whose behalf I am speaking. I am speaking on behalf of that body of persons whom the Editor of the Gazette, in a "Passim" note this week, with his usual happy choice of language, calls the Hospital Community. It is a community bound together by a common privilege of addressing you or at least of speaking of you, familiarly and affectionately, as the "Super"; a community bound together to-day by a common grief that they are so soon officially to lose this privilege, though I venture to think that many of us will long continue to exercise it, whatever new titles may be more appropriate to your future position or to any well-deserved honours that may be hereafter conferred upon you.

Every section of this community, Medical, Surgical, Dental and Specialist Staff, Nursing Staff, Staff of the Medical and Dental Schools, Administrative Staff, Past and Present Students in the Schools, and last, but not least, the Works Department, vies with each other in a desire to express its regret that you are so shortly to vacate your office of Superintendent of the Hospital, its pleasure that you have been made a Governor, and its earnest hope for your happiness in your new work and ultimately in your retirement, an event which, having regard to your abounding energy and love of work, seems indeed very remote.

Representatives from each section are present here to-day, and if some sections are less numerously represented than others I am sure it is to be attributed not to any want of enthusiasm for the object of this meeting, but to a certain shyness in which both you and I can sympathise with them. We are indeed grateful to you for allowing us this opportunity for saying our farewells and good wishes to you in person, knowing as we do how averse you are from all functions and ceremonies in which you are called upon to take a prominent part.

In the letter in which I was told that the committee arranging these proceedings had expressed a wish that I should act as spokesman, it was said that I had been chosen because it was believed that I was your oldest friend at Guy's and had been more closely connected than anyone else with your work here. I do not know how this may be, but I am sure we are very old friends and have done much pleasant work here together. Perhaps I may remind you of the beginning of our friendship. Thirty-three years ago you and I, unknown to each other, were applicants for the much-coveted post of Assistant Physician. The Governors of the Hospital in their wisdom declined my application and accepted yours. A few mornings later when going round the wards with my class as Medical Registrar, bemoaning, I daresay, the hard fate which had ordained that the unusual, if not unprecedented, action of the Governors in selecting for the Staff one who had not received his medical education at Guy's, should have apparently cut short my ambitions, Mr. Lushington, the then Treasurer, came into the ward and calling me from the bedside introduced me to the new Assistant Physician. From that day to this I have never for a moment ceased to be profoundly grateful to the Governors for postponing my election to the Staff, for by this action they secured for me one of the longest, closest, and happiest friendships of my life, and secured for my beloved Hospital what, I believe, its future historians will recognise as the greatest piece of good fortune that has befallen it during the first two centuries of its existence. Ever since that date you have devoted to the service of the Hospital your high intellectual attainments, your talents as a teacher, but above all, your incomparable powers of construction, organisation, and administration. During all this time you have lived amongst the Hospital Community, and for a large part of the time you have been accompanied by Lady Perry and your daughter, who have, like you, endeared themselves to many of its members, and to whom also we desire to convey our expressions of regret at losing their society and of good wishes for their future happiness.

There was a tale current when I was first a student here, which some of you have, no doubt, heard. A senior member of the Staff was taking round an American who did not appear to be very appreciative of what was being shown to him. Coming to the steps of the Colonnade and looking out into the Front Quadrangle, as a last effort, our former colleague said, "And here you see the statue of our Founder, Thomas Guy, standing amidst the buildings exactly as they were when he planned them 150 years ago and unaltered since the first patient was admitted just a week after his lamented death in the year 1725." To which the American replied, "I guess if your old man Guy had built his hospital in our country as long ago as that, we would have pulled the whole darned thing down two or three times by now and rebuilt it—better each time." Since you have been Superintendent, Guy's has been practically rebuilt, but we are grateful to you that you have not "pulled the whole darned thing down." So far as the progress of the standard of comfort of the patients and the demands of advancing science have allowed, you have retained for us the original structure and its best architectural features, so that we may ever be reminded of our ancient traditions and of our glorious past. The additions put up under your guidance and inspiration are numerous and now quite indispensable. The Residential College, the Dental

School, the new School Buildings, the Laundry and Central Power and Light Station, the Nurses' Hostel, the Pathological Institute, and many another new or enlarged department, all owe their origin and completion to your inspiration and energy. Only yesterday some of us attended the formal opening of the buildings of the Salomons Infant Welfare Centre, destined, let us hope, to be the pioneer of many further efforts here in the direction of Preventive Medicine. You are leaving us a yawning chasm in the Park, the foundations for additions to the nurses' quarters and for a new building for the Electrical and Remedial Exercise Department. You have already planned for us at the top of Hunt's House two new floors to accommodate a Baby's Ward, a new Clinical, extension of the Midwifery Ward, and wards for other special departments.

There are some who think the best and most permanent memorial of your work here as Superintendent will be these buildings. Others with heads for figures and high finance, think you may best be remembered by our banking account during the last thirty years. They point to the hundreds of thousands raised and spent on these permanent works and to the half million that has been added to the Re-Endowment Fund.

But things of the spirit are more enduring than things of the flesh and human societies often outlive the bricks and mortar in which they are housed or their bank balances however large and cautiously invested. Perhaps a still more lasting memorial of you than buildings or money may be the atmosphere which you have so largely helped to create for this great hospital community to work in. I am old enough to remember the time when our community was sadly rent by discord and dissensions. I am confident that there is no busy body of workers of equal size to-day whose mutual relations are so full of peace and good fellowship. You would be the first to recognise how largely this happy condition is due to those in still higher authority over us. But by example and precept you have taught us to make the interest of the individual subservient to the interest of the institution, and that the welfare of each department must be subordinated to the welfare of the hospital as a whole. You are binding us still closer to-day by inspiring us with a desire to render to you a common homage on your retirement.

I find myself quite unable to say all I wanted to say and all I want to say to you. Fortunately for me Dr. Fawcett, our Senior Physician will shortly read to you a few simple sentences to which we intend to append our signatures and hand to you as a lasting memorial of our regrets and good wishes. I will not attempt to add to these sentences. I will only now pledge this large meeting of your friends, colleagues, and fellow-workers to remember, and to remind each other, especially do I pledge the elders to remind their younger colleagues, of your unselfish devotion to duty during the long period of your office, believing that this memory will inspire each of us, as far as lies in his power, to endeavour to follow your example, so that in your retirement you may have the assurance that the traditional service of this great hospital shall ever be maintained and increased.

The Chairman then formally presented the various gifts from the different sections of the Hospital Staff. The gifts were as follows, each being suitably inscribed: —

A silver tea service, Georgian pattern (five pieces), and a silver tea caddy, Queen Anne pattern, by his past and present colleagues and students of the Medical and Dental Schools.

A pair of silver two-branched candelabra and a silver cake basket by the Administrative Staff.

An 8-day striking clock by the past and present Nursing Staff.

A silver cigarette box by the Staff of the Works Department.

Accompanying the presents will be an illuminated album containing the signatures in facsimile of the contributors, and the following address, which was read by Dr. Fawcett: —

To

SIR EDWIN COOPER PERRY, KT.

M.A., M.D.Cantab., F.R.C.P.Lond.

WE, whose names are here appended, tender you our affectionate regard on the occasion of your retirement from the post of Superintendent to Guy's Hospital.

For thirty-three years you have devoted a rare and keen intelligence which has never slumbered, to the fortunes of Guy's.

Coming to us as a Physician, with a mind richly endowed with ripe scholarship that has given a peculiar charm to your powers as a Clinical Teacher, you were very soon called upon to undertake additional duties as an administrator, first as Dean of the Schools and Warden of the College, and later as Superintendent of the Hospital, every department of which, many instituted on your initiative, bears the enduring mark of your singular gifts of practical efficiency.

Upon your courtesy no call has been too heavy. Your help and advice have always been at the disposal of the humblest.

In matters of discipline your decisions have ever been determined by a dominating sense of public duty dedicated to the claims of suffering humanity.

You have maintained and enriched the fame and lustre of the Foundation of Thomas Guy and given us each and all, professional and laymen alike, an example of high endeavour, self-denial and tenacious devotion that we would fain strive to emulate.

We gratefully acknowledge our debt.

January 29th, 1920.

The address and presentation was received with much cheering, and Sir Cooper replied :—

Dr. Fawcett, Ladies and Gentlemen, Friends all!—I have to thank you on behalf not only of myself, but of Lady Perry and my daughter, for the very handsome presents you have made me, and still more for the kindly spirit in which you are speeding the parting Superintendent.

Kindness indeed I have invariably experienced at Guy's from the first day I entered it some 32 years ago, when, a stranger from another and at that time somewhat despised hospital, I met Sir Thomas Stevenson on the top of the steps of the Colonnade, and, as is the fashion of Guy's, regarding me critically, but not unkindly, he said, "Now we have you, we shall expect you to work." I humbly, and I hope truthfully replied, "That I can do."

No sooner was I here than I realised that Guy's was a place where people worked. I saw the proofs of the quiet labours of generations in the Post-mortem Records, in the great collection in our Pathological Museum, and in the accumulated piles of Clinical Reports; and Mr. Wells used in his later years to repeat the remark which I made when I had been here some months and was meditating various improvements, that I believed the old place had a sound constitution. And I based my belief on the evidence all around me of steady honest work which was the joy of those before me and of my contemporaries, a spirit alive as ever in the present generation.

Now work may be done for many motives, for the honest motive of obtaining a competence, for the less worthy motive of advertisement, but the work we see and admire here is work done with no thought of advertisement about it, done by a worker with an ideal, an ideal which Bacon expresses in the words "the glory of the Creator and the relief of man's estate." And the labours of how many of us go to the task which the modern hospital sets out to fulfill.

I often think of Guy's as a coral reef, gradually raised above the water by the infinite minute accretions of toil contributed by every one of us. How many are the labourers all working to one end. You see us based upon the Works Department, the servant, perhaps, at times, the master, of us all; the Laundry, where we are washed more or less perfectly; Tabard House, where not with entire success they endeavour to carry out the Apostle's instruction that women should study to be quiet, but where they work as girls love to work when their heart is in it; the Kitchens, that cheap mark of satire; the Bakehouse; the Counting House; the Steward's Department and Stores; the Superintendent's Office; the Matron's Office; the Sewing Room, uncompromising in its exposure of any failure by a Nurse to conform to the only types there recognised as normal in the human female. All these departments I enumerate, and the list is not exhausted, before we even approach our Medical School and Students, the Sisters and Nurses, the Patients and the Wards, with their hierarchies male and female, from the Physician to the Household, or the Surgeon to the King, to the newest Probationer, who, if she only knows it, is entering on the happiest three years of her life. Such is the complexity of the machine, so great the task, to carry on the Commonwealth.

Now this work of ours, done for an ideal directed to the relief of man's estate, draws

us together as a family. We work together, we play together, at least some of us play. We share each other's sorrows, and what is often harder, each other's successes. If we win Football Matches—and we did sometimes win them even before the South Africans came over—we rejoice from the Senior Physician to the Lab. boy, and this community in work and play and in ideals makes us stick together in a fashion which is proverbial all the world over. Guy's men and Guy's women are credited with a clannishness binding us as closely as if we all came from the other side of the Tweed. Long may these ties of work and common aims remain firm fixed in the Boro.!

One fault, however, I have to find with those who have said such kind things about me; that, as is perhaps inevitable, they have exaggerated the importance of myself, who am just one single cog in the great machine. Not one of the achievements they lay to my charge could have been accomplished except as part of that machine. For example: the College, which was projected by Dr. Addison, actually came into being because we all pulled together —Mr. Lushington, our Governors, and Staff—and took the risks. The Dental School owes more to Mr. Newland-Pedley than to myself, and what a small affair it was when we left it compared with the magnificant structure into which it has developed through those who came after us. Our great appeal in 1896, what would have come of it without Mr. Bonsor, Sir Alfred Fripp, and Mr. Wells?

None knows better than myself how little I have done, nor should I be content to be thus praised did I not make it freely known that the praise you gave me is due in a far greater degree to the company of faithful workers and loyal sons and daughters of Guy's whom it was my lot to have as my companions and helpers through the whole of my service.

I am fortunate that the end of my time here has brought me what it ought to be the fervent prayer of all of us to find at the close of the long struggle with ourselves and with circumstances—a disposition to happiness, a composed spirit to which age has made things plain, an unrebellious temper, and hopes undimmed for mankind. These things I count myself lucky in possessing, for I am confident that the work to which I am going at the London University is the work to which Providence has called me, that in leaving Guy's I am doing what is best for Guy's, and that I am confiding the task which was mine to young and willing hands who will be proud of the past of Guy's, who will endeavour to show themselves worthy of their great inheritance. Once more I thank you.

Appointments.

Civil.

William Carling, M.B., B.Ch., to be Honorary Assistant Anæsthetist to the Royal Portsmouth, Portsea and Gosport Hospital.

A. L. Punch, M.B., M.R.C.P., Assistant Physician and Assistant Pathologist to Brompton Hospital for Consumption and Diseases of the Chest.

R. D. Passey, M.B., B.S., to be Griffiths' Demonstrator of Pathology as from October 1st, 1919.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—One of the London Colleges has adopted a very good scheme to preserve the memory of students who have fallen in the war, which, I think, might be copied at Guy's.

Around the walls of the main entrance are some 200 framed photographs of men who died whilst serving their country.

From time to time various photographs of Guy's men have appeared in the GAZETTE—more especially in the Memorial Number of December, 1918.

May I suggest that these photographs be reproduced in photogravure, mounted in similar frames, and hung in the College Reading Room? These might very well serve a two-fold purpose by being further reproduced in the Guy's Hospital Reports Memorial Volume.—I am, Sir, Yours faithfully,

A PRESENT STUDENT.

Guy's Hospital,
January 30th, 1920.

DEAR EDITOR,—I hope you will forgive my long silence. I have been occupied in compiling my text-book of Chinese Surgery, about which I hope to harass you in more detail later if you wish it. The book will be entitled surgical short cuts and aims at exposing the narrowness of European

conceptions of the scope of surgery. Your notions are conservative, ours are more plastic. You may sum up Chinese surgery in the word "Symbiectomy" or "Synthectomy." By this I mean that the surgeon aims at making one good operation rather than many bad ones. We think it better to send out from our hospitals only complete individuals, and anything less than this we retain for plastic purposes.

Thus our conception is quite the opposite to yours. You amputate the part from the individual; we amputate the individual from the part, and since by Euclid the part cannot be greater than the whole, it is clear that we have always something in hand to graft on to another patient, while at the same time anatomical studies do not suffer for lack of material.

The tendency then with us is to aim at co-operation between the patients, each giving his bit, so to speak, lending a hand, or giving a leg up to his fellow. We aim at symbiosis, two or more damaged individuals entering at the back surgery and one whole or synthetic individual leaving by the porter's lodge. Out of a ward of fifty beds there is sure to be enough material for making several complete individuals. The surgery which aims at this synthesis we call symbiectomy or surgical synthectomy.

At first we had difficulty in keeping the patients long enough for classification into groups wherein parts might appear approximately interchangeable. The one feature common to all was the Hippocratic facies, and many left without warning us. So we were grateful indeed for the return of Lung Ho, who comes back to us enobled with the diplomacy of your College of Surgeons. He explained to us your methods for keeping patients as long as you wish by the "palliative treatment." He told us of percussion and osculation in the wards, and also of the wonderful instruments you employ for convincing the patient that his illness is a permanent one, cardiographs, manometers and stethotrites, and the sigmoidoscope, through which he tells us you can always see a faint positive guaisc in the fæces. I suppose you borrow all these instruments from your Admiralty. It is wonderful to be a naval people.—Your humble servant,

HO. HO.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Leaves from a Medical Note Book
(1914—1918).

XII. Acute Capillary Bronchitis.

During the early winter months of 1917—more than a year before the first wave of the influenza pandemic—the Casualty Clearing Stations admitted a large number of cases of acute capillary bronchitis from among the forward area troops in France and Belgium. The cases were at that time regarded as influenzal infections. They were of extreme severity and showed a high mortality. At the same period laryngitis with aphonia, and also the respiratory complications of trench-nephritis showed a very high incidence.

The clinical features of the cases were briefly as follows: Usually with a history of only a day or two of illness, but sometimes with a history of unfitness for several weeks followed by an acute exacerbation, the men were admitted with pallor, cyanosis, and urgent dyspnœa. Cough with expectoration of creamy pus and streaks of red blood-stained sputum, a rapid pulse of poor quality, pain in the chest, and albuminuria, were usually noted. Signs of consolidation were absent, as a rule, but impaired entry over the bases, scattered rhonchi and moist sounds were nearly always present. In addition to albumen, casts were sometimes present. Organisms resembling Pfeiffer's bacillus were isolated from the sputum in four of the writer's cases.

One striking feature, apart from the deep cyanosis of lips and ears, was the enormous quantity of fluid, frothy pus which they expectorated; the sputum cups were filled to the brim in a few hours. Death within two or three days of the onset was not unusual. At autopsy the bronchioles were found full of thick pus. Probably in consequence of the rapid course of the disease macroscopic bronchopneumonia was not seen. The only treatment that was of any avail, and that only for the relief of symptoms, was the continuous administration of oxygen.

It is an interesting speculation as to whether this epidemic, which, it is believed, synchronized with a similar one among the home forces, can be regarded as a precusor of the 1918 pandemic.

J. A. RYLE.

(*To be continued.*)

The Treatment of Colles' Fracture.

BY ALAN H. TODD, M.S., B.Sc., F.R.C.S.

ALTHOUGH Colles' fracture is a very common one, the importance of thorough treatment of it is not yet widely appreciated, if the number of cases showing bad functional results that are referred to this Hospital can be taken as any criterion. This is much to be deplored, because it is quite easy to secure good results in practically every case, if correct treatment is adopted from the very outset; on the other hand, if it is not, no amount of subsequent treatment, operative or otherwise, will effect any improvement. A bad result after Colles' fracture means a lifelong disability, and this is a serious thing, when one reflects that the injury is most commonly seen amongst working people, that it affects the right arm more frequently than the left, and that a large number of cases occur amongst able-bodied persons, with a number of working years to look forward to.

It must be laid down emphatically that *perfect anatomical reduction is the first essential to the successful treatment of a Colles' fracture.* Without this, all else is futile. And not only must the reduction be perfect, but it must be speedy; experience has shown that late reductions never give as good results as early ones; if a Colles' fracture is put up badly, and the reduction has to be repeated in a few days 'time, the ultimate result will not be as good as would have been secured if the initial reduction had been perfect. It is hardly too much to say that the fate of a patient with Colles' fracture is decided by what is done to him in the first forty-eight hours after his accident.

The mechanism of fracture is constant, viz., a fall forwards, on to the outstretched palm, the hand being radially-deflected and the wrist extended at the time; the radius always breaks at the same place, viz., three-quarters of an inch from the lower articular surface; and as the determining factors are constant, the type of fracture that results is constant also. In a typical case, the lower fragment rotates backwards about a transverse axis, and it is more or less impacted into the upper fragment; moreover, as the hand is thrust violently round towards the radial aspect in the fall, a considerable strain is thrown upon the structures at the inner side of the wrist; the consequence is, that either the ulnar collateral ligament is stretched or ruptured, or else (more probably) the ulnar styloid process is torn off.

The damage being practically a constant one, the mode of reduction can be standardised also. *An anæsthetic should be used in all cases;* the process is very painful, and unless an anæsthetic is used, the reduction will almost certainly be imperfect, and that is one reason why so many bad results are seen; people will try to do the work without an anæsthetic, and therefore they do it badly. If the operator is expert, gas may suffice; otherwise, full general anæsthesia is preferable. The manipulation required is very easy to remember; the force employed is exactly the reverse of that which produced the deformity; for instance, in the fall, the hand was forcibly thrust backwards, and the wrist was hyper-extended; the hand should now be forcibly pulled forwards, and the wrist be hyper-flexed; this will overcome the backward rotation of the lower fragment. Next, the hand should be pulled strongly towards the ulnar aspect; this will undo the impaction and correct the radial deflection of the hand. Reduction is always easy, and should be complete. There seems to be a pernicious doctrine abroad, to the effect that perfect restoration of anatomical outline is by no means essential to the restoration of a good measure function, after fractures. This is never true, in the case of the lower extremity, which has to bear weight; and even in the case of the upper extremity, which does not have to bear the body-weight, it is only true in a minority of cases, and never in Colles' fracture. It is sometimes true, for instance, in fractures of the middle of the shaft of the humerus, where good function may be restored in spite of an inch or more of overlapping; it is true, too, in many fractures of both bones of the forearm, provided that pronation and supination have been carefully preserved; but it is never true in cases where any angulation of the bones has been allowed to occur. Angulation —that is the whole secret of the case; if the overlapping be axial only, it may not matter; but if there be angulation, the deformity must matter. The reason is not far to seek; when a bone is angulated, the muscular balance of the limb is upset, quite apart from any mechanical limitation of function that may result

from the faulty position; the muscles on the convexity of the bend are stretched and act at a disadvantage, whilst those on the concavity have the aid of leverage, and overact. One can draw an analogy with the familiar flexion of the knee that is liable to occur after excision; as long as the knee is absolutely straight, and the extensor and flexor muscles lie parallel with the shaft of the femur, no bending can occur; but if a little flexion be permitted, the flexor muscles act at a mechanical advantage, and very soon the small amount of flexion becomes a large amount. The same principle applies to the backwardly-rotated lower fragment, in Colles' fracture; but here it is the flexors that are at a disadvantage, whilst the extensors overact. Further, the extensors are relatively shortened, and become adapted, that is, contractured; this is an additional obstacle to flexion of the wrist. There are, therefore, at least three good reasons why flexion is restricted in imperfectly-reduced Colles' fracture: (1) the mechanical disadvantage of the flexor muscles; (2) the over-action and the contracture of the extensors; and (3) the limitation from mere wrong direction of the radial articular surface.

We assess the result of treatment in a case of fracture, not by mere restoration of anatomical outline, but by the degree of restoration of function in the limb as a whole, and in every part of the limb. In Colles' fracture neither muscular power, nor balance, nor normal range of movement can be restored, until perfect reduction has been attained, and all leverage has been abolished. That is why the doctrine before referred to is so pernicious; it suggests that by some mysterious process the results of bad workmanship can be compensated in the future; it puts a premium on bad work, and leads to imperfect reductions being let alone, instead of being corrected at the very first opportunity.

There are some who teach that if reduction has been perfect there is no need to use any splint after Colles' fracture, because the normal balance of pull between the extensor and flexor muscles has been restored, and therefore their only possible effect will be to brace the rough surface of the lower fragment all the more strongly up against that of the upper fragment. This is not altogether satisfactory, however, in actual practice; patients are liable to roll over on to the injured wrist and hurt it, during sleep, and very many of them are not yet educated up to the idea that a fore-arm fracture can possibly be successfully treated without splints. But these are minor objections; the main one is the mechanical fact that the fractured surface is not a vertical one, but an oblique one; the muscular pull, therefore, tends to reproduce the deformity, to a certain extent, and if no splint is used after disimpaction, the lower fragment often rotates backwards again. A splint, then, is desirable, in my opinion, for a short time, in all cases except that small minority in which impaction is left undisturbed. Carr's splint is very useful, if there is no tendency at all to recurring backward rotation of the lower fragment, *i.e.*, if reduction has been complete, and the fractured surface happens to be nearly vertical. It has the advantage that it is cheap to make, and is very comfortable; it should be affixed with three bands of strapping, one round the metacarpus, one round the lower part of the forearm, and one round the upper part of the forearm; this is better than bandage, because it does not interfere with massage, or with voluntary muscular movements. In all cases massage should be begun as soon as possible after the accident, and from the very first the patient should move the thumb and fingers to the full normal range. Special care should be taken to prevent any loss of flexion at the distal row of interphalangeal joints, for it is upon their perfect mobility that the efficiency of the grip depends. If the finger-tips cannot be flexed right down into the palm, the patient cannot grasp anything properly, and the flexibility of the other joints is more or less useless. By clenching the fist, and watching the movement of the distal row of joints, the reader can easily satisfy himself upon this point.

About three days after the injury the splint should be removed and the site of fracture firmly grasped, whilst active flexion at the wrist joint is carried out; after a further forty-eight hours the same movement can be carried out passively. (Active movements are always safer than passive ones, because they will never overstep the limits of discretion.) Supination should not be attempted till about eighteen days have elapsed, and even then much care must be exercised; in passive manipulations the surgeon should grasp the patient's forearm above the site of fracture in such a way that his fingers press upon the upper radial

fragment and help to rotate it; any attempt to supinate the forearm by grasping the hand will simply move the fragments upon one another and cause pain, without producing any real supination at all. Pronation will give no trouble, partly because the hand has been treated in pronation throughout, and partly because everything that one commonly does in daily life tends to promote pronation. In writing, feeding, dressing, and so on, one uses the hand pronated; there is hardly any action, however, except turning a door-handle, that assists supination. The result of all this is that flexion and extension of the wrist usually recover completely, under assiduous after-treatment, and with a patient's co-operation; pronation is never impaired, but supination is often limited to about three-fifths of the normal amount.

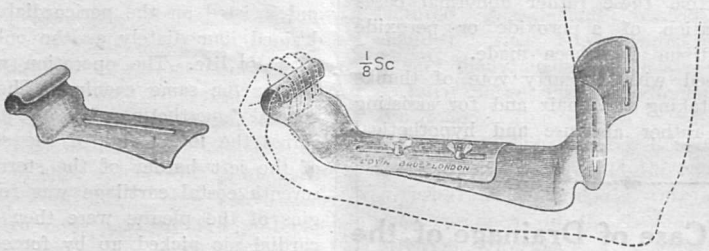
If there is any tendency for the lower fragment to rotate backwards, it is better to put the fracture up at first with the wrist hyperflexed. An anterior rectangular splint can be used, or, better still, a light plaster support; to make this, the fracture is first reduced, the skin is lightly vaselined, and then a single plaster bandage is applied without any wrinkles to the front of the forearm and hand, and the sides of the wrist, as far down as the heads of the metacarpals; if possible the hand should be deflected a little towards the ulnar side as the plaster is setting. When it is set, the splint is removed, its edges trimmed, and a layer of lint is placed in it as a lining; this gives a perfectly fitting splint, which is sufficiently flexible to allow of a slight amount of movement at the wrist, and at the same time is exceedingly comfortable, because it fits perfectly. Whichever form of bent-wrist splint is adopted, it should not be used for more than a week; by this time all tendency to backward rotation of the fragment will have disappeared, and if the position is maintained any longer there will probably be a certain amount of difficulty in getting the wrist to extend again, owing to adaptive contracture of the flexors and stretching of the extensors. My own practice is to use the dropped-wrist position for four to seven days, and then either to substitute a Carr's splint or, more frequently, simply to rest the hand and forearm in a sling. Indeed, no splint should ever be employed for longer than a week, in cases of Colles' fracture, and very often it is possible to dispense with them earlier; and in all cases the splint should be removed daily to allow of massage and active movements, and later on of massage with passive as well as active movements, as detailed above. It is only in cases of greatly-comminuted fracture of the atrophied bones of old people that any exception is permissible; and here it is recognised that the splint is kept on for a little longer in order to avoid causing them pain, whilst some impairment of function is practically inevitable in any case, in these patients. In all other patients the most efficient splint is the inflammatory effusion that follows the trauma; it spreads into all the soft parts around the fracture, including the tendons, the tendon-sheaths, and the narrow bony grooves about the wrist in which the tendons play. The tendons fit very tightly in these grooves, as anyone will appreciate who has tried to pull them out of their grooves in the course of a tendon-transplanting operation; and when effusion occurs they fit still more tightly, forming a very efficient splint. This splint, moreover, has all the mechanical advantage of an internal splint, closely applied to the bones, as contrasted with a mere external splint. After a day or two it is always sufficient to prevent any displacement, if the fracture has once been properly reduced; it holds all the parts very firmly together; indeed, it often holds them a great deal too firmly, for unless good after-treatment is employed the general difficulty with Colles' fracture is that it tends to become very stiff. That is why a certain amount of movement is necessary from the very first, and why it has to be gradually increased. On the other hand, the employment of any great amount of passive force is worse than useless. The result is simply the causation of so much pain that the patient insists on keeping the part at rest for several days, and by the time that the pain has subsided the wrist and fingers are stiffer than ever. If a Colles' fracture is not moved from the first, permanent impairment of function is a certainty, and no amount of subsequent treatment will cure it, or even improve it to any great extent.

Speaking generally, one may say that all patients with Colles' fracture who are under fifty years of age should recover with very useful wrists, whilst those who are over fifty usually have more or less impairment of function. In all young and middle-aged persons one ought to restore the full range of flexion and extension of the wrist, together with full

pronation. Supination, however, is often slightly impaired; having performed about three-fifths of the normal movement the patient compensates for the rest by adducting the elbow and rotating the arm at the shoulder-joint. For most ordinary purposes this will suffice, for, as we have already seen, supination is not a movement that is much required, and extreme supination is very seldom necessary. Now and again, however, one sees a patient in whom this restriction of full supination is a disability; for instance, I have recently seen two plumbers who both said that in consequence of their having lost the last 30 degrees or so of supination, they were unable to "wipe a joint" in awkward places, and both of them were sufficiently troubled by it to consent to operation to remedy their disability. On reflection, it appears that the only reason for supination becoming limited is simply the prevailing habit of putting up these fractures in full pronation. I have therefore devised a splint which allows of the valuable dropped wrist position being adopted, but in conjunction with full supination, instead of full pronation. It is made of thin sheet-metal, curved to fit the limb, and is adjustable for any length of forearm, whilst one or other of the two hand-pieces supplied will be found to fit any ordinary patient with Colles' fracture. It is fixed on with three pieces of webbing, or with strapping, and the position of full supination thus obtained is not at all irksome, even at first.

The splint will fit either limb, and is made by Down Bros. Practical experience has shown that it enables one to secure all the advantages of the older methods of treatment, with the additional advantage that there is never any limitation of supination. Pronation may be a little difficult when first the splint is removed, but in no single case has there been any trouble about getting back this movement; it comes back of itself, because it is a movement that one is constantly wanting, and cultivating, in everyday life.

To sum up, one may say that in every case of Colles' fracture in persons under fifty years of age, flexion, extension, and pronation should always be completely restored if only early and complete reduction has been achieved, and a suitable after-treatment has been adopted, whilst full supination can best be secured by splinting the limb with the wrist hyper-flexed and the forearm supinated.



Guy's Hospital Physiological Society.

A meeting of the Society was held on Friday, January 23rd. Mr. Ryffel kindly took the chair.

Mr. Warner read a paper on "The Mechanisms of the Oxidation of Foodstuffs in the Animal Body."

The ordinary foodstuffs, proteins, carbohydrates and fats were dyroxidisable substances and the oxygen in the air and blood was not able by itself to interact with these substances. Oxidation did not take place in one step, but there were a large number of intermediate products before the final stage of carbon dioxide and water was reached. Oxidation in the body was specific, e.g., only four out of the sixteen hexoses could be dealt with in the body, and in certain pathological conditions even these specific substances escaped, e.g., glucose in diabetes or homogentisic acid in alcaptonuria.

Theories of the activation of oxygen suggested the polymerisation into ozone and its subsequent decomposition, the splitting of the oxygen molecule into its atoms or the formation of unitable peroxides—the latter was the most generally accepted idea, and a large number of oxidative actions in the body bore a striking resemblance to the actions of hydrogen peroxide. The production of the peroxide was thought to occur by the action of a ferment or catalyst on some precursor which was always present, but the speaker considered that this addition of a ferment was merely a shield behind which the Physiologist hid his ignorance; it was far simpler to imagine that glands secreted specific peroxides which,

in contact with foodstuffs, liberated atomic oxygen and so oxidised the various substances.

The speaker then gave a brief outline of the stages of oxidation of the principal foodstuffs, and of the methods adopted to determine these stages.

The subject was then thrown open to discussion, and the question of peroxides, peroxidases and catalysts was debated. A great number of different views were brought forward, but the subject appeared to be very incompletely worked out, so that no very definite conclusions could be arrived at. There was undoubtedly a need for some specific activator of oxygen, and the unitable peroxide met the needs of the case most satisfactorily. Whether the peroxide was formed directly as a secretion of the gland or through the medium of ferment or catalytic action was uncertain. Mr. Ryffel considered that a double ferment action would be necessary, one to produce the peroxide and the other to break it down with the liberation of atomic oxygen. Specific oxidising ferments had been extracted from the dying tissues in a bruised apple and from certain fungi, but apart from these rather abnormal cases no direct identification of a peroxide or peroxide ferment in living tissue had been made.

The meeting closed with a hearty vote of thanks to Mr. Ryffel for taking the chair and for assisting the meeting on a rather abstruse and hypothetical subject.

A Successful Case of Drainage of the Pericardium.

H. P., a small boy, 11 years of age, was admitted into Stephen Ward on the 9th November, 1919, under the care of Dr. Beddard.

Two days previously he had complained of feeling unwell, and of slight pain in the thorax and in both knee joints.

The following day he had severe pains in several joints, chiefly the knees, and also in the præcordial region.

He was brought up to the Front Surgery the day after and admitted.

On admission his temperature was 102°, pulse 90, and respirations 35.

The knee, wrist and finger joints were swollen, painful and tender, and his general condition poor.

The day after admission patient showed the physical signs of pneumonia in the upper and lower lobes of the right lung.

Dr. Beddard saw the case, and diagnosed it as a "pneumococcal infection first manifesting itself in the joints and later in the right lung."

The pain in the joints gradually became less, and the joints themselves less swollen.

On the 21st November, 10 days after admission, patient asked to be allowed to sit up, and his condition appeared to be much worse. A pericardial rub was heard, and there was also an increased area of cardiac dullness extending into the left axilla.

Later there was an increase in the area of cardiac dullness, and signs of compression of the left lung by the pericardial effusion. Dr. Beddard recommended exploration of the pericardial sac, followed by incision and drainage.

Mr. W. E. Tanner was called in, and performed paracentesis of the pericardial sac under local anæsthesia, but owing to the child's nervousness gas and oxygen had to be administered, and about 10 c.c. of blood-stained fluid were drawn off containing some flakes of fibrin.

Bacteriological cultures were made, but no organisms found.

The patient showed signs of improvement for two or three days after the operation, but later he became worse.

Dr. Beddard saw him again on the 28th November, and insisted on the pericardial sac being opened and drained immediately as the only hope of saving the patient's life. The operation was performed by Mr. Tanner the same evening. The patient was given a general anæsthetic. An oblique incision was made across the lower end of the sternum, and a portion of the left border of the sternum together with the seventh costal cartilage was resected. The two margins of the pleuræ were then defined, and the pericardial sac picked up by forceps and incised. About 30 c.c. of fluid came out. A fairly large rubber drainage tube was then inserted under the heart into the oblique sinus.

The alteration in the condition of the patient two days after the operation was remarkable. He began to evince an interest in his surroundings, and was very much more comfortable.

His temperature, which had varied between 100° and 102° previous to the operation, now fell to 99°, and varied between that and 100° for about a week, gradually coming down to normal.

The tube was shortened on the second day, and again on the fifth day. The pericardium was meanwhile draining fairly freely. The distal end of the drainage tube could be seen pulsating at each heart beat, and on the removal of the tube the heart could be seen beating at the bottom of the wound. The tube was gradually shortened, and finally removed on the 13th day.

The patient improved rapidly in weight and appearance; for about a fortnight after the closure of the external wound the heart was slightly irregular in its action, but gradually became more regular.

There were no further signs of pericarditis or other abnormal physical signs in the chest, and on

the 2nd January he was up on a couch. On the 5th he was well enough to walk, and is now ready to be discharged from the ward.

I am indebted to Dr. Beddard for permission to publish this case.

H. M. BROWN.

Antiquarian Discoveries at Guy's Hospital.

(Continued.)

Summary of Roman and Romano-British Pottery and other Relics found.

Decorations. Many of the fragments of pottery unearthed were very beautifully decorated. One piece which from its texture appears to be of German manufacture has a mounted warrior brandishing a club, while underneath the fore legs of the horse is a small cross, and further on the figure of a woman, possibly a representation of Perseus and Andromeda. In addition to the "festoon and tassel" design, figures in medallions of various animal forms, such as eagles, running dogs, etc., separated by intervening decoration of the cruciform type, were of frequent occurrence. Flat dishes were often decorated with the ivy pattern in slip, others with palm leaves, while the larger types of bowls bore conventional designs known to have been used by the potters of Lezoux and of other centres.

Mortaria. Many fragments of Roman mortars or basins (pelves). They are of grey ware, the former characterised by the inner surface being studded with numerous fragments of quartz either embedded in the surface or incorporated in the clay mass; the latter present a smooth inner surface. On the rim of one piece is stamped the name APRILIS, who was a potter of Lyon.

Castor Ware. This type of pottery was manufactured in Germany during the 1st Century A.D., particularly round the Lower Rhine districts, e.g., at Cologne. From there the art was brought to England, where, amongst other places, it was practised at Castor, the ancient Durobrivæ in Northamptonshire, probably during the Third Century. This pottery has not the same fine texture nor the brilliant red of the so-called Samian ware, being a greyish colour and having a dark exterior coating or engobe said to have been produced by the use of a smother kiln in "firing." The decorations when present are *appliqué* work combined with barbotine in which a decorative slip in white cream was applied generally in flowing curves. A number of bases bore on their under aspect an incised cross, apparently the potter's trade mark.

Upchurch Ware. The next most frequent specimens found were fragments of Upchurch ware, so named on account of many specimens having been found near Upchurch and other villages on the banks of the Medway. It is distinguished by its texture and usually globular form.

New Forest Ware. A few fragments of indented ware, so named from depressions on its outer aspect which have apparently been made by the potter's thumb. Large numbers of specimens were discovered in the New Forest at Fordingbridge, hence the name.

Miscellaneous Remains.

Lamps. Several complete specimens of Roman earthenware lamps. One that I had the opportunity of examining was about 4 inches in length and about $1\frac{1}{4}$ inches in height.

Jar. An almost perfect specimen of a jar made of greyish pottery, possibly Upchurch ware. It has a very narrow foot or base, so that it probably stood in a stand, as the amphoræ are said to have done.

Glass. It is well known that the Romans manufactured glass; and several pieces of "pillar moulded" glass bowls were unearthed. The glass is very finely made, and has a slight greenish tinge. A fairly large piece of Roman window glass was also found.

Seal-Box. The lid of a Roman seal-box of bronze and decorated with a bluish coloured enamel design.

Spoon. A bone spoon very similar in design to some specimens in the London Museum.

Votive Offering. A curious find was a piece of horn about four inches in length, at one end about half an inch square and tapering to a point at the other. This type of article is well known, but its uses remain a mystery, although it has been suggested that it might have been a votive offering, although this seems rather unlikely.

Oyster Shells. Large quantities of oyster shells were found in the Roman layer, and also in the layers above, thus confirming the well-known fact that British oysters were thoroughly appreciated by the Roman invader.

Tiles. A number of ribbed Roman tiles, probably flue-tiles. In spite of this nothing that could definitely be stated to be Roman foundations was found.

There can be no doubt from these various remains that from about the middle of the First Century A.D. and even earlier and probably up till about 400 A.D. the site on which Guy's Hospital now stands was occupied by Roman buildings of some importance. Soon after the departure of the Roman legions to defend their own country from the invading Goths, the Anglo-Saxon, a far more barbarous and ruthless conqueror than the Roman had been, began his war of conquest and colonisation.

Late mediæval relics were the earliest post-Roman remains found.

(To be continued.)

Pass List.

Royal College of Surgeons, Edinburgh,

FELLOWSHIP FINAL EXAM.

N. S. Carruthers. A. B. Danby.
G. H. G. Pochin.

Conjoint Board.

CHEMISTRY AND PHYSICS.

*S. R. G. Pimm.	†J. Dywien.
D. Vaughan.	*H. McLachlan.
S. C. Olver.	†F. N. Newell-Roberts.
*W. F. Payne.	†F. J. Levy.
R. R. Macintosh.	†A. B. Davies.
H. C. Warner.	

†Chemistry only. *Physics only.

BIOLOGY.

E. Bowen-Jones.	J. E. Jones.
J. L. Faull.	B. Rubinstein.
R. Frankling.	G. W. Murray.
H. Slater.	L. E. Owen.
L. B. Helder.	R. R. Macintosh.
S. T. Hine.	F. N. Newell-Roberts.
J. L. Hopkins.	D. Vaughan.
G. C. Hughes.	A. B. Davies.

Society of Apothecaries of London.

SURGERY.	MEDICINE.
*G. K. Reeves.	J. G. Barrie.
	J. Kendall.

*Completed the examination.

PRIMARY EXAMINATION—ANATOMY AND PHYSIOLOGY.

H. T. Chiswell.

Royal College of Surgeons.

L.D.S.—PRELIMINARY SCIENCE EXAM.

*C. H. A. Fido.	D. H. Oliver.
A. S. Davies.	*A. K. Van Nickerk.
J. G. Coutts.	F. A. Kerrison.
J. S. de V. du Toit.	C. Hardwicke.
†S. J. Van Schalkwijk.	T. C. Butter.
W. O. Bailey.	†H. J. Luck.
J. H. Reid.	*C. C. Brattle.
*R. A. Tran.	H. A. Clarke.
J. C. Faure.	F. N. Van der Pant.
†J. P. Hartman.	*F. G. Hutchinson.
*H. K. Banks.	†G. B. Kempster.
L. Evans.	†L. Levinson.
F. A. Sampson.	†G. G. T. Haynes.
E. H. L. Sander.	†H. J. Walters.
†W. E. Silver.	*R. Edwards.
R. Maxwell.	*C. L. Steyn.
*F. H. Hayne.	

†Chemistry only. *Physics only.

Lawn Tennis Club.

The Annual General Meeting will be held in the Anatomy Theatre at 4.15 p.m. on Monday, February 9th, Dr. Fawcett in the Chair. Business—Election of Officers, etc., for coming Season. All people interested in the game should attend!

Football.

GUY'S v. LONDON SCOTTISH.

One wants to avoid anything like vulgar crowing in these reports, which are intended to convey to Guy's men far and near a vivid impression of the particular match in question, interesting news of Hospital Rugby, and helpful criticism of the match and players. The writer can scarcely avoid a loud crow, though, over this win and last Saturday's. The football played by the XV. on Saturday, January 24th, at Honor Oak Park, was, from half-time to the end, splendid. The stand for the second Saturday in succession turned many away, and the wires burst with the pressure of spectators on the touch line. At 3 o'clock the teams turned out; at 3.5 Van Schalkwijk sold the dummy and profited by a clever try, which Neser failed to convert. Nothing more was scored for the rest of the half, during which both sides passed well and ran well, and if Williams could have run in side or side stepped we should, through Krige's cleverness, have got two more tries. Williams did well all the same, though he could not quite pass the full-back. Olivier went down to all the Scotch rushes, and was rewarded with a Scotch boot well in his face and then neatly drawn over his right cheek, but he kept his line from falling. Guy's tackled well, but they must go low like they did against the Services.

Resuming with the wind a little behind us, Shellswell, ever near the ball, got a try. Then Krige put Williams in with a beauty. Many backs handled before Krige got it; Van Schalkwijk goaled. Will players in possession think more of the line and go for it like the——well, like Daneel does when he means it. To look round is to miss a chance and lose pace. If a man backs you up, you will hear him if he wants the ball. Sprong got a nice couple of tries. Bekker sent along a stream of passes which the backs handled splendidly, and Van Schalkwijk was cleverness itself. The forwards, however, were the real thing. They ran, backed up, tackled and passed; the eight were on the ball, and if the others who all did so well do not mind I would specially mention Watson, whose display was grand. The next try was gained by Watson. Really clever was Marais' run and Reitz's splendid following of the ball, which enabled the last named to get our seventh try. The eighth came from Van Zyl. Van Schalkwijk gathered from Bekker. What an asset he is, hard working and so thorough. The three-quarter ran hard, broke towards the centre and was tackled, but Neser instantly picked up and handed on for Van Zyl, who grounded beneath the bar. Van Schalkwijk had made his total four goals, and Reitz converted the last named. Guy's, 5 goals 3 tries; 34 points to nil. Guy's team:—

W. Olivier, H. K. Williams, J. A. Krige, J. Van Schalkwijk, A. Daneel, E. L. Sprong, F. Bekker, F. W. Reitz, G. E. Kidman, A. H. Shellswell, L. K. Watson, A. Marais, E. E. Neser, H. Van Zyl, and R. R. F. Duncan.

The match proved that physical fitness, given the skill the XV. possess, is our most valuable asset in the coming Cup Ties.

GUY'S v. H.A.C.

This match was played on January 31st at Chingford.

The ground was very muddy, and in places almost a swamp, but that is no excuse for the poor display given by the Guy's team. The opponents, winning the toss, kicked down a slight slope with a strong wind behind them. For the whole of the first half our defence was very hard worked, the forwards being unable to control the ball to any purpose. The opposing centre-forward was always dangerous, and after 10 minutes' play scored with a hard shot. Immediately after they were awarded a penalty and scored. The Guy's attack could make no headway, and before half-time the H.A.C. scored again.

After crossing over the wind was a great help, and the opponents' goal was often in danger, until a centre from the left wing was beautifully headed in by Pengelly. Guy's continued to play up well, and the inside forwards nearly scored several times. The H.A.C. then rallied, and registered two more goals in quick succession. Then, after working hard, our centre-forward scored a well-deserved goal. Time came with the score at 6-2 against us.

Guy's were a lighter team, and this was a great factor in the result, but for many it was an "off-day," and there was a tendency to lose heart instead of sticking it to the end. With Coxon back in the team for the Cup ties this will be remedied.

Soccer Notices.

1ST TEAM.

January 10th.—v. Bank of England. Lost 3-2; scorers, Smith (1) and Trott (1).

January 17th.—v. King's College at Wormwood Scrubbs. A pleasing feature in this game was the fine combination among the forwards. The first half was even, but Guy's, as the result of a first-time shot by Coxon, crossed over with the lead. During the first ten minutes of the second half King's College pressed, and were at length rewarded by a goal—a very fine shot by their right half, which gave May no chance. After this Guy's played up splendidly, Pengelly scoring from a pass by Coxon. Trott scored soon afterwards, leaving Guy's the winners by 3 goals to 1. Guy's team:—

R. C. May, C. A. Wakeford, A. W. Riddolls, F. Rayner, P. O'Meara, D. H. Couch, R. Van Geuns, R. Pengelly, C. Coxon, L. A. S. Trott, and G. P. Lindsay.

Guy's are drawn against "Barts." in the first round of the Inter-Hospital Cup. This will be played off one day next week.

2ND TEAM.

January 24th.—v. Bank of England; lost 1-2.
January 28th.—v. Brentwood School; won 4-1.
January 31st.—v. East London College; draw 2-2.

The draw for the Junior Inter-Hospital Cup takes place this week.

Reviews, etc.

Syphilis in Childhood. By Leonard Findley, M.D., D.Sc., F.R.F.P.S.G. (Oxford Medical Publications) pp. 148, with six coloured plates, and 37 illustrations in the text; price 8s. 6d. net.

This little book gives a very full and useful summary of all the syphilitic affections of childhood, methodically and clearly set forth. The author possesses the happy knack of putting things in such a way that they are easy to be remembered, and he is to be congratulated on creating a work which should prove invaluable to the vast numbers who are now taking an active interest in child welfare, and, indeed, pediatrics as a whole. It is impossible to exaggerate that portion of their work with which this book deals, and every budding pediatrician or welfare worker should read it from cover to cover.

Commencing with a brief chapter on nomenclature, the author then gives an interesting chapter on the mode of infection. Perhaps this chapter in parts is a trifle obscure—a criticism which cannot be levelled against any other part of the book—but the subject itself is wrapped in obscurity. Then follow short but "pithy" chapters on the incidence and infectivity of the condition, succeeded by what is perhaps the best section in the book—that on the early symptoms. Every early symptom is here methodically and clearly described, giving abundant evidence of the care bestowed upon the work by the author. This is nearly equalled by the next chapter on "Lues Tarda." The salient points of the preceding chapters are then summarised under the heading of "Diagnosis." The last chapter is an excellent one, being a complete and very practical little essay on the treatment of the condition. The "tips" for obtaining blood for Wassermanns and for intravenous medication in the infant are most useful, and show that this is the work of no "arm-chair" philosopher, but of one who understands the innumerable little difficulties that beset both the novice and the expert. The whole book is made living by numerous case histories, illustrations in the text, and coloured plates; the last, with one exception, being remarkably good.

Notices.

Great Ormond Street Hospital.

There will be a meeting of the Joint Committees on Wednesday, 18th February, 1920, to elect a Physician to Out-Patients.

Candidates, who must be Fellows or Members of the Royal College of Physicians of London, are invited to send in their applications, addressed to the Secretary, with copies of not more than three testimonials written specially for the purpose, at or before 12 o'clock, Monday, the 16th February, 1920.

All candidates will be required to appear before the Joint Committees on Wednesday, 18th February, at 5 p.m.

Forms of application and copy of the rules can be obtained from the Secretary.

By order of the Committee of Management,
JAMES McKAY,
Acting Secretary.

January, 1920.

British Medical Association.

MIDDLEMORE PRIZE, 1920.

The Middlemore Prize consists of a cheque for £50 and an Illuminated Certificate, and was founded by the late Richard Middlemore, F.R.C.S., of Birmingham, to be awarded for the best Essay or Work on any subject which the Council of the British Medical Association may from time to time select in any department of Ophthalmic Medicine or Surgery.

The Council of the British Medical Association is prepared to consider an award of the Prize in the year 1920 to the author of the best Essay on the following subject:—"Perimetry (Inclusive of Scotometry), its Methods and its Value to the Ophthalmic Surgeon."

Essays submitted in competition must reach the Medical Secretary, British Medical Association, 429, Strand, W.C.2., on or before April 30th, 1920. Each Essay must be signed with a pseudonym, and accompanied by a sealed envelope marked on the outside with the pseudonym, and containing the name and address of the author.

In the event of no Essay being of sufficient merit, the Prize will not be awarded in 1920.

ALFRED COX, M.B.,
Medical Secretary.

January 9th, 1920.

Ophthalmological Society of the United Kingdom.

The next Annual Congress of the Society will be held on Thursday, Friday and Saturday, 29th and 30th of April and 1st of May, 1920.

The arrangements will be as follows:—

THURSDAY, APRIL 29TH.

Morning. At the Royal Society of Medicine, 1, Wimpole Street, W.1.—10 a.m. to 12.30 p.m., President's opening address; papers.

Afternoon. At the Royal London Ophthalmic Hospital, City Road, E.C.1.—3 p.m., Clinical meeting; exhibit of books, museum specimens, drawings and portraits belonging to the Hospital; members will dine together in the evening.

FRIDAY, APRIL 30TH.

Morning. At the Royal Society of Medicine, 1, Wimpole Street, W.1.—10 a.m., Discussion on "Diabetes in Relation to Diseases of the Eye." To be opened by Sir Archibald Garrod, Mr. R. Foster Moore, and Dr. E. Spriggs. The following also intend to speak:—Dr. Leyton, Mr. G. Mackay, Dr. Poynton, Mr. P. H. Adams; Dr. Cammidge, Mr. Gray Clegg, and Dr. A. Renshaw.

Afternoon. 5.30 p.m., Business meeting.

Evening. 8.30 p.m., Papers.

SATURDAY, MAY 1ST.

Morning. 10 a.m., Visit to St. Margaret's Hospital, Leighton Road, N.W.5., the Special Hospital of the Metropolitan Asylums Board for cases of Ophthalmia Neonatorum; discussion on "The Prevention and Treatment of Ophthalmia Neonatorum," to be opened by Dr. Gibbon Fitzgibbon, Master of the Rotunda Hospital, and Mr. M. S. Mayou. The following intend to speak:—Mrs. Scharlieb, Dr. Macrory, Messrs. Sydney Stephenson, Maitland Ramsay, and J. Wharton.

Members desirous of reading papers, showing cases, or taking part in the discussions, are requested to communicate as soon as possible with Mr. F. A. Juler, 24, Cavendish Square, London, W.1.

Papers and communications, subject to the judgment of the Council, will be printed in full in the "Transactions."

Under the Bye-laws readers of papers must not exceed twenty minutes, subsequent speakers ten minutes. The openers of the discussions are allowed twenty minutes.

All Communications must be type-written.

R. R. JAMES. F. A. JULER.
Hon. Secretaries.

Change of Address.

Capt. F. H. Wallace, 4, Victoria Terrace, Ryde, Isle of Wight.

Geo. Elkington, Llwyngril, S.O., Merioneth (rtrd).

A. H. Clogg, 42, Devonshire Street, Portland Place, W. (Tel. Padd. 2253) and 128, Church Road, Upper Norwood, S.E.19 (Tel. Sydenham 1004).

R. C. W. Staley, 11, Kings Terrace, Southsea.

A. L. Punch, 5, The Pryors, Hampstead, N.W. (Tel. P.O. Hampstead 1202).

W. R. Reynell, M.D., M.R.C.P., 26, Nottingham Place, W.1.

Sir Josiah Court, J.P., Staveley, near Chesterfield.

A. C. Dean, Stanhope House, Carnarvon Road, Clacton-on-Sea.

J. Millard Barnes, The Knoll, Fittleworth, Sussex.

Surg.-Lieut.-Commander H. L. Peregrine, M.B., B.S., R.N., c/o Admiralty, Whitehall, and Branston, by Belvoir, Grantham.

Brevet Lieut.-Col. F. S. Brereton, C.B.E., M.D., Feldon Lodge, Boxmoor, Herts.

C. W. Woolloton-Baxter, Langford, Maryland Road, Bowes Park, N.22.

H. W. Webb, 21, De La Warr Rd, Bexhill, Sussex.

Capt. A. P. Marsh, R.A.M.C., Military Hospital, Lancaster.

H. J. Campbell, Brackley, Southtown, Dartmouth.

E. S. Bowes, Seymour House, Totnes, South Devon.

J. L. Perceval, 17, Dukes Avenue, Muswell Hill, N.10.

B. R. Parmiter, M.B., B.S., 10, West Borough, Wimborne, Dorset.

T. F. Wilson, M.B., B.S., Hill House, Clay Cross, near Chesterfield (Tel. Clay Cross 6).

L. Ta Bois, 15, Upper Wimpole Street, W. (Tel. Padd. 1202).

Capt. H. W. Evans, 9, Dynevor Road, Bedford.

Owen E. Williams, Fron Hane, Mold, N. Wales.

W. E. Tanner, M.S., F.R.C.S., 48, Philbeach Gardens, S.W. 5.

Birth.

BURRIDGE.—At Swanage on January 24th, to the wife of Capt. W. Burridge, R.A.M.C., a son.

Marriage.

RITCHIE—BLYTH.—On January 20th at St. Michaels, Berechurch, William H. Ritchie, of Ruiru, British East Africa, to Ruby Sarah, youngest daughter of Mr. and Mrs. R. P. Blyth, Berechurch, Colchester.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

ON Thursday, February 5th, His Royal Highness The Prince of Wales, accompanied by Sir Sidney Greville, paid his first visit to Guy's Hospital. He was received in the Quadrangle with great enthusiasm by the residents, nursing-staff, and students, and proceeded to the Court-room, where he presided over a meeting of the Governors, called to consider and make the necessary arrangements for a public appeal for funds.

After the meeting the Prince visited the various departments of the Hospital, accompanied by Mr. Cosmo Bonsor, Mr. Whitbread, the Hon. Sir Sidney Greville, Mr. H. L. Eason, and Miss Hogg. Beginning at the Chapel, His Royal Highness passed through the Colonnade, where his appearance was greeted with renewed cheering, and entered several of the wards. The Prince of Wales also went into the Operating Theatres, and the Light Department. He concluded his round of the Hospital by visiting the Dental Department, and left Guy's at 3.30 p.m.

Perhaps the most pleasing feature of the whole afternoon was the kindly way in which the Prince shook hands with practically every ex-service patient in the wards, and addressed to each some words of greeting and encouragement.

It is unnecessary to add how gratified all Guy's men were by the interest His Royal Highness evinced in the welfare of the Hospital and by his great personal charm of manner.

THOSE who remember Prof. C. E. Groves, F.R.S., F.C.S., F.I.C., will regret to hear of his recent death on February 1st. He was lecturer on Chemistry and Metallurgy at Guy's until 1901, when he retired. Apart from his great chemical knowledge, Professor Groves was a man of considerable general ability. He was one of the founders of the Institute of Chemistry, and edited the journal of the Chemical Society from 1884 until 1899. During his stay at Guy's, Professor Groves earned the regard and affection of all who knew him.

WE regret to have to announce the death of another old Guy's man—Dr. Frederick Hazell. An old colleague speaking of him says, "He was well known and highly respected by all who came in contact with him at the old Hospital."

Dr. Hazell was a student from 1888 until 1894. In the latter year he left Guy's and opened a practice in Capetown. Here his kindly spirit and high ability won him universal respect and love. Of Dr. Hazell a correspondent in "The Cape" writes "Ask the poor, who loved him, whom he loved, and among whom he laboured incessantly day in, day out, for more than a quarter of a century, and they will tell you—'The Doctor was a proper gentleman.' This is the highest eulogy that can be framed on the lips of the poor; when they have said that, they have said all." It is men like Dr. Hazell, working in a quiet and conscientious way, who carry all that is best in the spirit of Guy's, with them, to the ends of the Empire.

DURING the last four weeks the Pupils' Physical Society has held three meetings. These were all extremely interesting, but the attendance has been somewhat meagre. This was owing to the fact that the audience mainly consisted of senior men, while people just commencing their clinical work were conspicuous by their absence. This is a pity. It is impossible for a Registrar or the author of a text-book to do full justice to any particular subject. Both are limited: the Registrar by time and the author by space. The result is that the average student accepts as dogma theories and ideas upon which there exists the greatest possible differences of opinion. At an open discussion such as is possible at the Physical Society, however, one learns to view ideas in their right proportion, and anyone who is at all interested in medicine, as soon as he commences his ward work, would do well to try and develop that broad vision which is the criterion of a good practitioner. After all, our time at Hospital is short, and there is much to be learned.

THE Secretary of the Clubs' Union comments in this number of the GAZETTE on the spirit of Bolshevism which is manifest amongst a certain section of Guy's men, who have removed periodicals (leather covers and all) from the College Reading Room.

Mr. Winston reports that the same spirit is rampant in the Wills' Library, and wishes it to be known that books borrowed from the reference library must be returned on the same day. Subscribing members may, however, retain a volume overnight, but should return it on the following day. To borrow and keep important works of reference for several weeks at a time causes great inconvenience to others, and is blameworthy indeed; but the man who abstracts journals from a public reading room deprives others of their daily food for reflection, and is nothing short of a barbarian.

Appointments.

Civil.

William Carling, M.B., B.Ch., to be Honorary Assistant Anæsthetist to the Royal Portsmouth, Portsea, and Gosport Hospital.

H. Webb, M.R.C.S., L.R.C.P., to be Assistant Medical Superintendent, Greenwich Union Infirmary.

A. E. Wood, L.D.S., R.C.S., to be Dental Surgeon to the Dorset Education Committee.

Dr. John Fawcett has been elected a Councillor of the Royal College of Physicians of London.

Honours.

C.B.E.

T. D. Lyster, M.D., Temp. Capt. (Act. Maj.), E. S. Marshall, M.C.

O.B.E.

J. Lewin Payne, E. C. Greenwood, J. Z. Hanafy, J. I. Palmer, O. B. Shelswell, J. H. Barnard, W. F. R. Burgess.

To be Brevet Major—Capt. A. C. Rook.

Some Suggestions as to the Duty of the State in the Control of Venereal Disease.

(FROM THE MEDICAL WOMEN'S FEDERATION)

Your Committee has given much time to the consideration of the problem of stamping out venereal disease, and to the various social questions connected with it. We desire to emphasise our considered belief that the problem is one of great complexity, and that its consideration involves far-reaching social questions. A close study of the history of prostitution and venereal disease has convinced us that it is impossible to separate this problem from the various social and moral questions with which it is connected. To grapple successfully with these diseases will involve a radical reform of the social conditions and moral habits of the society in which the disease flourishes.

It is common knowledge that in tuberculosis the policy of merely attacking the disease directly has proved itself a failure, and most instructed opinion is now turning to the control of the conditions which allow the growth and dissemination of the tubercle bacillus. The same is true of the attempts to eliminate every other infection. The anti-malaria campaign has found it necessary to drain and treat swamps and stagnant water, in which the disease-bearing mosquito thrives. In fact, every well-directed and successful attempt to eliminate disease has found it necessary first and foremost to direct its efforts to the retification of the social and hygienic conditions under which the disease flourishes. After much thought we have unanimously arrived at the conclusion that the chief and most important part of the task with which society is faced is such a reform of our social structure and of our moral habits as will gradually eliminate from society conditions which have led to the prevalence of venereal disease.

In the case of every other infection the problem is comparatively simple, as the campaigns against the disease and against the conditions under which it flourishes can be simultaneously pursued. In the case of venereal disease, the difficulties are much increased by the fact that activities along one line may, unless very carefully planned, to a great extent stultify and destroy the other half of the campaign. For this reason we feel that the utmost caution should be exercised and the problem considered from all its aspects and in all its implications before the community lays down its line of action.

The principal cause of the dissemination of venereal infection in a modern community is promiscuous sexual intercourse. Any action which neglects this fact, or which may even tend to increase promiscuous intercourse, is bound, we believe, to fail to decrease the spread of the disease, and may even lead to its increase.

Much the most important factor in the cure of the disease is early treatment, and any method of dealing with the disease which is likely to lead those infected to conceal their condition and to delay treatment will be a most dangerous expedient and may easily lead to a serious increase of the disease. These two facts must be borne in mind in considering the desirability of any method of grappling with the disease, and we believe that no method has any chance of success which neglects either or both of these factors.

The principal means which have been up to the present suggested for a direct campaign against venereal disease are:—

1. The examination and registration of prostitutes—so-called Regulation.

2. Notification of venereal disease.

3. Compulsory treatment (with its necessary adjunct compulsory medical examination).

4. Penalisation of the conveyance of venereal disease or of an attempt to have connection when in an infected condition as in D.40, D.O.R.A.; Sexual Offences Bill, Clause 1; Criminal Law Amendment Bill, Clause 5.

5. Prophylaxis, including "the packet system."

6. Early preventive treatment—the provision of public stations for cleansing and disinfection immediately after connection.

Regulation.

All systems of Regulation which have been tried have proved failures, and the method is hardly likely to be revived. Dr. Abraham Flexner, who has studied the whole question of prostitution in Europe and whose book is an accepted authority, tells us that "a verdict unfavourable to Regulation has been found . . . not because it violates personal liberty,

but because it fails; because it is at least useless in respect to order and worse than useless in respect to venereal disease." (Flexner's *Prostitution in Europe*, 1917 edition, p. 359).

Consideration of the history of Regulation leads us to the view that the failure is due *inter alia* to three principal causes:—

(a) The prostitutes examined and registered are never more than a small fraction of those carrying on the trade of illicit intercourse in the area and the setting up of a system of Regulation invariably increases the number of the unrecognised women, and so the sources of infection and probably the amount of indulgence.

(b) No examination which has been devised is able to ensure even a moderate amount of safety. Infection may be conveyed by women themselves free from the disease (mediate infection). The most careful examination may fail to detect signs of disease in women who are infected.

(c) The fact that by Regulation the State and Public Authorities recognise this traffic as inevitable, and make the safeguarding of it part of their hygienic machinery, leads to a false sense of security and to the feeling that sex indulgence is necessary and is provided for by the Sate, hence individual self-control is diminished, the moral standard of the community is lowered, and the amount of irregular indulgence, therefore, is likely to be increased.

It may be thought unnecessary, owing to the acknowledged failure of Regulation, to introduce these arguments, but we feel that the same arguments apply to a very great extent to many suggested new methods. We therefore think it well to point out the fundamental unity of Regulation with these newer suggestions.

NOTIFICATION AND COMPULSORY TREATMENT.

Notification is, in our opinion, impossible until we have a legally accepted criterion of infectivity. It can hardly be suggested that notification should be based on the mere existence of a positive Wassermann, or the existence of a discharge of muco-pus in which gonococci cannot be found, though we know that many of these last cases can be infectious and remain infectious through long periods of years. Even were accurate notification possible, we think it would be undesirable, because it would do nothing in itself to diminish infection if it were merely numerical and no names were given. If numerical notification is to be a step towards the notification of name and address in order that in case of need patients who neglect to complete their course may be persuaded or compelled to do so, then the arguments for and against compulsory treatment apply. Notification of this sort, which might be followed by compulsory treatment, would entail the risk of a certain amount of publicity, visits from an official who would be known by sight, proceedings in police courts, etc., and would in consequence deter patients from seeking treatment at the early stage of the disease, when it is most important, and so lead to the concealment of early cases. Patients would only seek advice when driven by pain and illness, when in most cases the disease has become incurable.

PENALISATION.

It is true that to infect an individual with venereal disease is a very grave offence deserving of severe punishment, yet we would point out that the difficulties of penalisation are very great, and, in our opinion, insurmountable. They have already been illustrated by the working of Regulation D.40, D.O.R.A. The proposed Clause 5 of the Criminal Law Amendment Bill and Clause 1 of the Sexual Offences Bill, which extend the offence to both sexes, would not in any way diminish the difficulties. It has already been proved that what amounts in practice to a compulsory medical examination is necessary to the working such a Regulation. In one case, under D.40, D.O.R.A., the Medical Officer of a Venereal Clinic was called upon to give evidence of the attendance of a girl at the Clinic in order to prove the fact that she was infected with venereal disease. (See Report of Proceedings Marylebone Police Court, April 18th, 1918.) It is hardly necessary to point out that such a possibility would certainly deter patients from seeking treatment, and would lead to concealment of disease. Flexner is entirely opposed to any system involving compulsion as he says it "continues the hurtful association of venereal disease with the police . . which must be completely uprooted if persons ill of venereal disease are to seek treatment as readily as those ill with measles or mumps." (Flexner's *Prostitution in Europe*, 1917 edition, p. 357).

Also in practice it would be impossible to obtain reliable evidence on which a verdict could be placed as to whether a plaintiff had been infected by the defendant or *vice versa*, or in some entirely different way. Besides which there is as yet no method known of determining with certainty whether a person is entirely free from infection.

The infection of one partner in marriage would, in our opinion, more properly be dealt with under the laws concerning divorce and nullity of Marriage.

In the infection of children, Sec. 12 of the Children Act, 1908, can be put in force, whereby a severe penalty is imposed on anyone causing a child or young person "unnecessary suffering or injury to his health."

PROPHYLAXIS.

The so-called "packet system" is at the moment one of the most popular methods for the prevention of infection. Its advantages have been described widely in correspondence in both medical and lay press, specially by the members of the Venereal Prevention Committee (see *British Medical Journal*, October 4th, 1919). In this matter we desire to associate ourselves with the findings of the Interdepartmental Committee on Infectious Diseases in connection with Demobilisation.* It is obvious from this Report that even under the conditions of discipline of men on active service during war there was no proportionate reduction in the infection rate of those sections of the forces in which the prophylactic packet system was most thoroughly used. In the British Forces the infection rate remained practically the same throughout the war, though during the latter part of it the packet system was very largely used, while in the Australian Forces, where the system was used probably more thoroughly and with more enthusiasm than in any other section, the infection rate was considerably higher at the end than at the beginning. (See Col. Harrison's Remarks, *Journal of the Royal Sanitary Institute*, September, 1919, p. 100.) In certain units of the forces, however, where during the recent war the "packet system" was used with great zeal and energy, the percentage of venereal disease is said to have been afterwards very markedly diminished (see paper by Sir Archdall Reid, K.B.E., M.B., C.M., F.R.S.E., page 85, *Journal of the Royal Sanitary Institute*, September, 1919.) It must be remembered that the zeal and energy of the administration was certainly not confined to this one method of stamping out the disease. Also the very fact of the enthusiasm and activity of the officer in command would communicate itself to the whole unit, who would be stimulated to use precautions against the disease. It would be impossible that such personal influence should make itself felt when the system became part of the general civilian sanitary administration. The Civil Health Authorities could not command and control the general population as can be done in the Army. The evidence laid before the Interdepartmental Committee on Infectious Diseases in Connection with Demobilisation points to the conclusion that though "certain drugs, if properly applied, are efficacious in preventing venereal disease," yet it is not possible in the Army, and would be still less possible among the civil population, to make certain that the drugs were properly or skilfully applied. The immunity obtained by their use would be quite certainly incomplete. We agree with the Committee in its statement that the issue of prophylactic packets "tends to give rise to a false sense of security, and thus to encourage the taking of risks which would not be otherwise incurred," and also that "under any mechanical system which does not give absolute protection, the venereal incidence must be proportionate to the risks taken," and we hold that if the introduction of such a system leads to an increase in the number of exposures, as would, we consider, be practically certain to be the case, it might very easily absolutely increase the spread of the disease.

We desire to point out that in the case of women either prophylaxis or early preventive treatment would be used as a preventive of conception. The complete carrying out of such a system must include the distribution of packets and the placing of posters drawing attention to the system in public lavatories and other suitable places. Whether or no safety could be obtained, promiscuous intercourse would be looked upon as free from risk of infection and to a great extent free from risk of conception and as recognised and protected by the State and Health Authorities, who would become in the eyes of the ignorant the consenting party to their actions. We believe that by no such method can the problem of venereal

*Cmd. 322. Prophylaxis against Venereal Disease

disease be met and that a phase of society would be produced as vicious and degenerate as any of which history has record. Safety from infection would not be attained, while moral degeneration and sex excesses would rot the very foundation of society.

We wish to make it quite clear that we are not advocating the retention of disease in order that the fear of infection may deter from promiscuous indulgence. Our point is that promiscuous indulgence would not be safe, while the attitude of the State would encourage the false idea that it was safe and countenanced by the Authorities, and so would inevitably lead to increased indulgence and quite possibly to increased disease.

EARLY PREVENTIVE TREATMENT.

The provision of early preventive treatment at the public expense at clinics by skilled nurses, male and female, which clinics are to be open at all hours of the day and night, so that sterilisation of the parts may be skilfully carried out within a short time of the act is also condemned by us, for the same reasons for which we condemn the prophylactic packet system. We protest against the use by the Public Authorities of any such system, which must lead to the impression that casual intercourse is being made safe and countenanced by the State, and so to the destruction of the sanctions of conduct in sex matters on which our society is based.

The sale by chemists, to those who wish to purchase them, of calomel ointment or of permanganate of potash solution is a matter with which we have no concern as long as the public is aware that these things are not remedies for venereal disease and that chemists are under a legal obligation not to sell them for the purpose of treatment of these diseases.

CONSTRUCTIVE POLICY.

The problem of the control of venereal disease can be adequately met only by an honest recognition of the causes of casual intercourse in a modern community, and by an organised attempt to eliminate them as far as possible. Among the causes of promiscuous intercourse is, we believe, a public opinion which accepts a different standard of morals for men and women, and consequently does not demand that men should live continent lives before marriage, and even regards with a certain leniency infidelity in the married. Of late years the tendency has been to extend to women the same lenient views with regard to chastity, and at the same time casual intercourse has notoriously been more common among women. This fact suggests that public opinion is a real factor in determining the standard of conduct in a community. We urge the teaching of a single standard of morality for the two sexes, and of insistence upon the fact that continence for either sex is compatible with health and well-being. It must be understood that it is absolutely impossible to demand chastity of women while allowing licence to men, the only possible outcome to such a demand being continence of some women with degradation of others to a position which is a danger to the community. We recognise the profound difficulties entailed, not only upon young men but young women in the practice of continence under existing social conditions. We strongly urge social reforms which would tend to minimise these difficulties. Such are:

Facilities for early marriage.

Facilities for divorce, where otherwise people would be doomed to a celibate life for causes such as, for example, incurable insanity and chronic alcoholism, such facilities for divorce to be equal for men and women.

Adequate reform in housing conditions.

Provision by the public authorities of opportunities for both sexes to enjoy rational recreation together, and share their social life and public work.

Provision for study and higher education for both sexes, and a real share in the organisation of the society in which they live.

The discouragement of the system of segregating either sex for long periods of time, thus removing them from the influences of home and normal social relationships.

The recognition of the important part played by alcohol as an ally of promiscuous intercourse, and so of venereal infection.

TEACHING OF CHILDREN.

The training of children in sex and allied subjects and the teaching of habits of self-control from infancy is, the Committee recognises, an essential part of the campaign. Such teaching should prepare the children for school life by giving them beforehand a standard of what is clean and decent in conversation and

conduct, and should gradually satisfy all questions regarding child-birth, sex and allied subjects in such a way as to leave in their minds a pure idea of the sex relation of men and women and a sense of the responsibility of each individual. Such teaching should, at any rate in the earlier stage, be undertaken by the parents, but it is the ultimate duty of the Education and Health Authorities to see that adequate teaching is provided. The training should be carried on along definite moral and scientific lines during the years of development and before children go out into the world they should have definite instruction regarding venereal disease and the dangers of sex irregularities.

SOLICITATION.

The Committee disapproves of that part of the Vagrancy Act dealing with solicitation. It is of opinion that the laws concerned with solicitation and similar offences should be abolished and replaced by a law making it an offence to annoy, molest, or insult, or try to converse with any person against his or her will. But a person who, of his own initiative neglects to or on the invitation of the police refuses to charge or appear against the person who molests or annoys him shall be deemed not to have been molested or annoyed.

Evidence of some person other than a member of the police force shall be necessary for a conviction.

AGE OF CONSENT.

In our opinion, the age of consent should be raised to 18, and should be the same for both sexes. The present law, which allows a man to seduce a girl of between 14 and 16 with impunity if in the opinion of the court she has the appearance of a girl of 16, should be done away with. We think that no exception should be allowed in the application of the law protecting persons of either sex below the age of 18 from indecency, assault or seduction.

REGISTRATION AND INSPECTION OF LODGINGS FOR YOUNG PERSONS.

We urge that there should be a systematic scheme set up for the registration and inspection of lodgings occupied by young persons, but under no circumstances should this inspection be in the hands of the police.

BROTHEL KEEPING.

We are in favour of the infliction of a severe term of imprisonment with or without the infliction of a fine, in every case of persons convicted of brothel keeping.

OTHER REFORMS.

There are certain other reforms which would, we believe, tend to have a wholesome effect, such as:

REFORM OF POLICE COURT PROCEDURE.

We are of opinion that in any case involving women or children, requiring the exclusion of the public, some respectable woman who is neither a paid police court or prison officer nor a party to the case, nor a relative of any such party, shall be called to be present throughout the hearing of the case, and that women should not be excluded from hearing any case involving women and children where men are allowed to remain.

WOMEN MAGISTRATES.*

We urge the immediate appointment of women magistrates.

WOMEN POLICE.

We are of opinion that a force of women police should be established adequate in numbers and with the full powers and duties that are exercised by men police.

SUMMARY.

In summing up, the Federation is aware of the criticism which will certainly be offered to this report, that all the suggestions made, though valuable, will be slow in coming into operation and that the urgency of the danger to the community demands some measure which shall be prompt and effective. We acknowledge the urgency of this danger, but we reiterate our belief that the measures which have been suggested for the stamping out of infection would neither be prompt nor effective in their action. It is questionable whether they would diminish infection at all: they might quite possibly tend to increase it.

We think that the results of the radical measures of reform which we suggest would

*Since this Report was adopted a number of women magistrates have been appointed.

be quickly apparent and cumulative. Public opinion can be changed in a generation, nay, in a few years, and the instruction of children may bear fruit practically at once.

In concluding, we desire once more to emphasise our conviction of the necessity of the most serious consideration of the whole problem and the avoidance of hasty and panic legislation. The problem is one of far-reaching complexity, its consideration involves many complicated social questions, the reformation of social conditions and of the moral habits of society. A remedy which does not include consideration of these will fail in its attempt, and probably draw new social evils in its train.

We urge that free, secret efficient treatment for all patients suffering from venereal disease should be provided by the State, and that every area should immediately take steps to provide adequate treatment, and we reiterate the importance of avoiding any legislation which may have the effect of deterring patients from seeking advice at the earliest possible moment.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—As Secretary of the Students' Club, I wish to protest against the spirit of Bolshevism which is rife amongst the members. Considerable efforts are being made to rescue the Club from its old war-time state of disorder. The results of this campaign have, so far, been most evident in the Reading Room, but progress is hampered, almost continuously, by the depredations of those very members for whom the work is being given. Periodicals disappear and are often taken away for days at a time. During the past week-end about three-quarters of the journals and their leather covers were removed from the Club's premises, and up to the time of writing have not been returned. It is almost impossible to furnish the room with pens, ink, and blotting paper, because of the rapidity with which they are diverted from public to private uses. The continued existence of a Club of this kind is impossible unless the members practise the elementary rules of citizenship.—Yours faithfully,

19, Cavendish Square, W. 1 — N. MUTCH, Hon. Sec. Students' Club.

Guy's Hospital Musical Society.

A general meeting of the Guy's Hospital Musical Society was held on Tuesday, January 20th, with Mr. Mollison, the Treasurer, in the chair. The Society was reconstituted on the basis of the pre-war organisation, and an executive committee, representative of the various musical interests in the Hospital, was elected, with the Matron as Chairman. Mr. Gallagher and Mr. Maurice Shaw were elected secretaries in place of Mr. S. Cohen and Mr. Lake who have resigned. Both of them will be pleased to hear from any student who is interested in the reconstruction of the Society.

The activities of the Society for the present session will be confined to choral work, and the Society has been fortunate in securing the services of Mr. H. St. J. Bradford, the Hospital organist, as conductor. Under his capable direction a considerable amount of choral work has been got through during the winter months, and it is hoped that it will be possible to give a concert before the summer. The choral practices are held at 8 p.m. on Thursday evenings. More men, especially those who can read music fairly well and who are prepared to sing tenor, are needed. If there be any such in the Hospital it is hoped that they will communicate with one of the secretaries. At present it seems unlikely that it will be possible to revive the orchestra which used to play such a prominent part in the Society's concerts before the war. Its ultimate revival is, however, greatly to be desired, and this end will be hastened if instrumentalists (especially strings) will get into communication with the secretaries as soon as possible.

There seems to be no reason why the Society should not flourish as it did in the days before the war, especially when the number of students at present at the Hospital is considered. Nevertheless, its reconstruction, even so far as it has gone at present, has not been without its difficulties, though these would be greatly lessened if not entirely removed if all those students who are interested in music would lend more active support to the recently revived activities of the Guy's Hospital Musical Society.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Antiquarian Discoveries at Guy's Hospital.

(Concluded.)

Remains of Indefinite Date.

Close to that portion of the excavations running towards the Nurses' Home and embedded in the layer of clay for the depth of a foot or so, large unshaped boulders, some of chalk and others of limestone, were found. Among these were what appeared to be the remains of wooden uprights (? posts or piles) some of which were charred. The boulders were loose and showed no definite method of arrangement. Among them was found a rather fine portion of an oval vase made of thin, reddish-brown earthenware, about four inches high and bearing on its base, which measured an inch and a quarter in diameter, three lines roughly incised which intersected one another,—probably the potter's trade mark. This pottery is of Early British origin, and its discovery is somewhat suggestive as to date, and the layer above, giving evidence of having been disturbed, one would be disposed to consider these remains as having been placed there by human agency. Previous to Roman times the site of Guy's was an impassable swamp. It is said that the Romans built a citadel on the north bank of the river, a bridge crossing the Thames about this spot, and in addition constructed a causeway doubtless of piles and stones running south. It may be that these remains were the basis of such a causeway or even, perhaps, of a dwelling. When the excavations for the building of Messrs. Down Bros. were being made, part of a causeway of similar construction was discovered.

Remains in Middle Layer.

Fragments of pitchers, jugs and earthenware vessels of mediæval origin were not as abundant as Roman pottery. Some small pots made of Lambeth delf were unearthed and a fragment of one of them bore part of the name of the unguent it contained, so it is possible that in those times a hospital, or at least an apothecary's shop stood on the present site of Guy's. Lending colour to this suggestion is the discovery of the decorated handle of a pewter "bleeding-dish" or bowl, a relic of the days when venesection was one of the main items in the stock-in-trade of the barber-surgeon. The handle in this case was ornamented with incised work and pierced, but sometimes in addition they are lettered.

Part of the handle of a purse and a bone fish about an inch and a quarter in length, used probably as a counter in card playing, were discovered. In the upper parts of the middle or mediæval layer quantities of horns and bones were unearthed. Most of these were of oxen and sheep, but a few were human and, I believe, a skull was also found. Oyster shells as in the Roman layer beneath, were still very abundant.

The only coin belonging to this period was a fragment of a gold coin—a quarter noble—which was probably of the time of the reign of Edward III., 1327—1377. The explanation of the absence of coins during this period is that until the time of Charles II. there was no copper coinage, and for some centuries prior the silver penny was our lowest coin, and they were centuries in which the purchasing power of the penny was no small thing.

Belonging to a later period was the discovery of a "coin-weight" used by the old-time money lender for testing whether the coins he dealt with were genuine or otherwise.

More Recent Times.

In the most recent stratum of all the following coins, etc., were found :—

Reckoning Counter, Hanns Krauwinckel, Nurenberg, 1580—1610.

Reckoning Counter, probably French, 1583.

Reckoning Counter of Charles V., early 16th Century.

Halfpenny, James I., 1606.

Farthing, Charles II., 1660—1685.

Irish Farthing, Charles II., 1660—1685.

Farthing Token, William Bissy, Milton-next-Sittingbourne, 1660—1668.

Farthing, Charles II., 1674.

Scottish "Turner," Charles II., 1677.

Nurenberg Counter, 16th to 17th Century.

Halfpenny, William III., 1700.

Farthing, George I., 1719.

Halfpenny, George II., 1721.

Halfpenny, George III., 1773.

Farthing, George III., 1773.

Penny, George III., 1797.

Close to the Nurses' Home and formerly covered by the Clinical Buildings, a brick-lined well, which seems to have been built before the erection of the hospital, was found. It was about five feet in diameter and was only about twelve feet in depth, having been partly filled in. In this portion of the excavation there was more surface water than elsewhere and the lowest stratum was composed of a bluish alluvial clay.

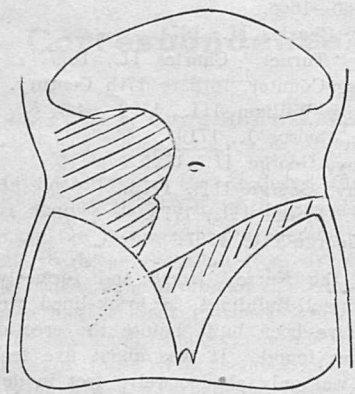
Clay tobacco pipes having bowls of small capacity placed at an obtuse angle to a long stem were found in very considerable numbers and belonged probably to the Stuart period. When the makers' marks are present on the "heel" of the pipe as is sometimes the case, it is possible to give the exact date of their manufacture, but the examination of a number failed to show any marks by which this could be ascertained.

A rather interesting discovery was that of a statuette made of baked pipe-clay. The head had been broken off, but the figure was that of a female. It was about two inches in height and bore on the base the following German inscription HIER . HIN . ICH.

In concluding this series of papers I must express my indebtedness to Dr. Hensleigh Walter, F.S.A., of Stoke-under-Ham, for very many useful criticisms and suggestions. J. ALLAN BERRY.

A Case of Splenic Anæmia Treated by Splenectomy.

W. McK., æt. 22, was admitted to Addison on the 29th August, 1919, for anæmia and swelling in abdomen. He was very deaf, and also had interstitial keratitis. He first noticed swelling in the left hypochondrium about July, 1919. This was most noticeable after a day's work. His urine also became very dark in colour, and a fortnight before admission he had an acute attack of diarrhœa, which soon passed off. There has been no pain. A week previous to admission he noticed a great alteration in his complexion. He had always had a fresh colour, but is now distinctly sallow. He has lost a little weight.



On examination of the abdomen the liver was found to be easily palpable to the extent shown in the diagram. The spleen was very large and had a well defined edge. The heart was pushed upwards and inwards towards the middle line. Anteriorly a loud rub was heard over the spleen. There was well-marked secondary anæmia and slight leucopenia. The blood gave a positive Wassermann reaction. The urine normal.

Dr. Hurst saw the patient on September 1st, 1919, and diagnosed splenic anæmia. As the rub became less audible and finally disappeared, it was decided to operate at once, in order to prevent the formation of dense adhesions which would have made it impossible to remove the spleen.

Mr. Bromley operated on September 8th. The spleen showed recent adhesions to the liver and diaphragm and there was universal pensplenitis. The spleen was removed; it measured about 10 inches long and 9 inches wide. The patient made a good recovery.

A blood count was done before and eleven days after the operation by Dr. Nicholson, and it is interesting to compare the two :—

	Before Splenectomy.	After Splenectomy.
Hæmoglobin	... 64%	... 64%
Red Blood Count	... 4,000,000	... 4,390,000
White Blood Count	... 7 160	... 12,680
Polymorph.	... 78·4%	... 42·2%
Lymphocytes	... 13·6%	... 32·2%
Hyalines	... 7·2%	... 15·0%

It will be noticed that there is a great difference in the polymorph. and lymphocytes, the former decreasing and the latter as well as the hyaline cells increasing. The Wassermann reaction was still positive. The patient has been to Out-Patients lately and is looking much better; he has quite a good colour and is gaining weight.

I am much indebted to Dr. Hurst and Mr. Bromley for permission to publish this case.

E. HARDY.

Change of Address.

Mrs. H. M. Cones, c/o Capt. H. M. Cones, A. C. Police, Baghdad, Mesopotamia.

H. E. Shepherd, 7, Cavendish Place, Cavendish Square, W.1. (Mayfair 3501).

Capt. F. K. Escritt, 35 General Hospital, Calais, B.T. in France.

H. Webb, Greenwich Union Infirmary, Vanbrugh Hill, S.E.10.

Percy J. Prond, L.D.S., 60, Russell Square, W.C.1. (City 9124).

Capt. R. H. C. Pryn, 33rd C.C.H., Haifa, Palestine. E.E.F.

E. Gardner Browne, L.D.S., 5, York Road, West Norwood, S.E.27.

Mrs. L. Debenham, 16, Pavilion Sq., Scarborough.

H. Millett, 83, Portland Place, W.1. (Mayfair 1450)

Capt. J. Stephenson, R.A.M.C., M.C., c/o Messrs. Holt & Co., 3, Whitehall Place, S.W.

S. G. Townley, Woodbourne, Knoll Road, Camberley, Surrey.

Capt. G. F. Peters, R.A.M.C., 21, Terrace Road, Sittingbourne, Kent.

Lawn Tennis Club.

The Annual General Meeting of the Guy's Hospital Lawn Tennis Club was held on February 9th, 1920, in the Anatomy Theatre; Dr. Fawcett in the chair.

The minutes of the last Extra General Meeting were read and approved and signed by the President. The meeting then proceeded to elect the officers and committee for the coming season.

1. A motion, proposed by Mr. Hodgkinson and seconded by Mr. Daneel, was carried, that the election of captain be held over to the last week in May (as was done last year), when an Extra General Meeting should be called so that a Captain could be elected when the probable constitution of the 1st VI. would be more definitely known.

2. Mr. Hodgkinson having resigned his post as Hon. Secretary, Mr. B. L. Laver was proposed and seconded as Hon. Secretary. He was elected unanimously.

3. It was proposed by Mr. Hodgkinson, seconded by Mr. Olivier, and carried, that the eight members of the committee to be elected (the Captain when elected to make the ninth) should be chosen as representatives of the various years of study—1st year, two members; 2nd year, one member; 3rd year, one member; Seniors, two members; Dentals, two members.

The committee elected were :—J. W. Schollum, G. A. Lawson-Brown, E. E. Neser, W. Olivier, R. J. Hodgkinson, J. Totton, J. van Schalkwijk, and J. Krige.

4. Dr. G. H. Hunt, proposed by Mr. Hodgkinson seconded by Mr. Laver, was unanimously elected a Vice-President of the Club.

5. The meeting concluded with a hearty vote of thanks to Dr. Fawcett for so kindly presiding.

Fifty-two members were present.

At a meeting of the secretaries of the London Hospitals' Lawn Tennis Clubs, held at St. Bartholomew's on Feb. 9th, the following points were decided with reference to the running of a United Hospitals' Lawn Tennis Team—

1. That each Hospital be entitled to enter four players for the trials.

2. That the trials be held on Guy's Hospital Ground on Sunday, May 9th, or Thursday, May 13th.

3. The following were chosen as a selection committee—Mr. Urwick (Bart.'s), Mr. Hobbs (Thomas's), Mr. Hodgkinson (Guy's), Mr. Paton (Mary's), with the general secretary, Mr. E. W. Williams.

Below is appended the draw for the Senior and Junior Inter-Hospital Cups—

SENIOR CUP.

	1st round.	2nd round.	3rd round.	Final
1. Bart.'s (holders), bye ...				
2. Charing Cross, bye				
3. Mary's, bye				
4. Royal Dental ...				
5. U.C.H.				
6. London				
7. Guy's...				
8. Middlesex, bye				
9. St. Thomas's, bye				
10. George's, bye				

JUNIOR CUP.

	Final.
1. London	
2. King's	
3. Guy's (holders) ...	
4. Thomas's	
5. Royal Dental... ...	
6. Middlesex	
7. Bart.'s	
8. U.C.H.	

Rounds to be completed on the following dates—

June 1st—1st round Senior.
June 14th—2nd round, Senior; 1st round, Junior.
June 28th—3rd round, Senior; 2nd round, Junior.
July 11th—Final, Senior; Final, Junior.

Pass List.

Royal College of Physicians of London,

M.R.C.P.

T. I. Bennett. G. Marshall.

Royal College of Surgeons and Royal College of Physicians.

D.P.H.

W. E. Fox. A. F. Knott.

University of Cambridge.

January, 1920.

M.D.

B. W. M. Aston Key.

M.B., B.Ch., 3rd EXAMINATION.

G. L. Attwater. O. G. Morgan.
A. C. Coxon. G. H. Oriel.
R. B. P. Lansdown.

CONJOINT EXAMINATION.

PHARMACY.

T. Reed.
A. W. Hall.
F. M. Newnham.
E. N. C. Annis.
M. Bannounah.
R. J. Hodgkinson.
D. B. Whitlock.
L. K. Watson.
D. G. Robinson.
R. M. L. Still.
L. R. A. Wells.
P. G. Sedgwick.
A. Tom.
C. E. Gallagher.
E. T. Lloyd.
J. B. Gregor.
C. W. Greenway.
S. P. Meacock.
S. B. Sugman.
M. Markiles.
P. Hock.
J. S. Hudson.
E. Sorabjee.

CONJOINT FINAL EXAMINATION.

Medicine.

C. M. Probert.
*G. P. Lindsey.
*G. Massie.
E. E. D. Gray.
T. Reed.
L. Moss.

Surgery.

*G. Massie.
*N. V. Wadsworth.
*P. J. Briggs.
*M. Coburn.
*H. N. Shapiro.
*E. C. Gray.
*W. A. Turner.
*A. C. M. Coxon.

Midwifery.

*G. Massie.
T. W. Turner.
R. M. Patterson.
H. Amin.
W. Remington.
M. Rose.
H. A. Crowther.
E. F. Wilson.
F. W. Crook.

*Denotes completion of exam.

Royal College of Surgeons.

1ST PROFESSIONAL EXAMINATION.

Mechanical Dentistry.

H. Greaves.
P. J. Walters.
A. Havenga.
C. M. A. Pauw.
H. J. Walters.
J. Levy.
J. L. de Koch.
W. R. Hursthouse.
H. H. Pickett.
G. J. Van Schalkwijk.
A. A. R. Madgwick.
P. Domb.
B. J. M. Keyter.
G. E. Price.

Dental Metallurgy.

H. Greaves.
F. A. Meyer.
T. E. Breveton.
O. F. A. Krause.
J. Levy.
P. J. Walters.
C. Glassington.
O. G. Morris.
A. A. R. Madgwick.
H. K. Banks
A. W. Greenwood.
M. B. Wells.
J. W. E. Warren.

Reviews, etc.

Radiography in the Examination of the Liver, Gall Bladder, and Bile Ducts. By Robert Knox, M.D. (Messrs. William Heinemann, Ltd.) Price 7s. 6d.

Radiography has successfully demonstrated the presence of gall-stones in a number of cases. Dr. Knox assesses the value of radiographic examination and emphasises the importance of technique. His work is a scientific investigation and he justly refrains from the unwarranted enthusiasm of the "90 per cent." optimists. His experimental evidence shows that all gall-stones will give a shadow on the photographic plate when removed from the body; the difficulty of demonstration in situ depends on the frequency with which their density approaches that of the surrounding tissues.

Although a negative report is of no value, "the future of the diagnosis of gall-stones is full of promise, if the investigator realises that it is possible to get very fine detail on the plates and if he is prepared to devote a great amount of attention to the technique."

The book (which is reprinted from the "Archives of Radiology and Electrotherapy, 1919) contains experimental, clinical, and historical notes and abstracts, and is well illustrated.

Surgical Operations.—A text book for Nurses. By E. M. Hey Groves. (Oxford Medical Publications.) Price 21s. net.

This text book supplies a long-felt need in the nursing profession, as, unfortunately, some nurses do not get much experience in the operating theatres during their training. The illustrations are numerous and very clear, and each operation is treated in so concise and simple a manner that it can be readily understood by any first year nurse. It is a little disappointing that in the chapter on General Surgical Technique, more details of the preparation of the operating room and materials and appliances which must always be in readiness are not discussed. These matters are essentially the nurse's responsibility, and one feels that this excellent book should contain more guidance for them. For example, no mention is made of the dry sterilisation of non-cutting instruments, which is now so generally practised, or of a head lamp in the description of a mastoid operation, and many surgeons would find the author's lists of instruments for different operations rather scanty. Details of the anæsthetic requirements are also lacking. In spite of this Surgical Operations will prove an invaluable addition to every nurses library, and the nursing profession should be very grateful to Mr. Hey Groves for the infinite trouble he has taken on their behalf.

Physiological Principles in Treatment. By W. Langdon Brown, M.A., M.D. Cantab., F.R.C.P. (Messrs. Balliére, Tindall & Cox) crown 8vo., pp. viii. + 427; price 7s. 6d. net.

How often one hears a senior student complain that the time spent learning physiology was to a very large extent wasted! And yet a glance at this justly renowned book, which has now reached its fourth edition, shows plainly how great is the error into which the grumbler has fallen, for not only are the best of the old methods of treatment, which the student has picked up empirically in the wards of his hospital, here set forth in a clear, concise and most readable manner, with a reason given for each particular procedure, but also a host of new suggestions are brought before the reader, made rational and interesting in the light of the most recent physiological discoveries. Furthermore, the book, despite its title, contains much more than mere treatment. Diagnosis, symtomatology, and pathology are constantly being referred to, always in such a manner that it is difficult to forget one fact after having read it as expressed in this work.

It is difficult to pick out chapters which are in any way outstanding in merit—for in so doing one is tempted to copy out the list of contents at the beginning of the book. However, if we were compelled, we should especially recommend the sections on the "Rational Treatment of Gastric Disorders," "The Work of the Pancreas," and "Glycosuria and Diabetes." The author is to be congratulated on having made a valuable addition to the student's armament. Every man, in our opinion, should read this book from cover to cover twice—once before he starts his clinical work, and again shortly after qualification.

Herman's Difficult Labour. Revised and enlarged by Carlton Oldfield. (Messrs. Cassell & Co., Ltd.) Price 16s. net.

This book has long held a deservedly high place in medical literature. The sound practical advice of an experienced obstetrician has helped many a harassed practitioner in the past.

The author of this new edition has set himself the task of modernising this old friend by judicious omission and additions without sacrificing essential characters. We cannot help feeling that while the pruning process might have been carried further with advantage, the tradition of dogmatic teaching has been carried a little too far. Mention of the vectis, for instance, is hardly called for, nor, in the chapter on placenta prævia, need reference have been made to "Simpson's method: delivery of the placenta first," though it is true that the text continues: "the practice . . . has not been followed by good results."

On the other hand, the very emphatic condemnation of vaginal plugging for placenta prævia is not justified in view of the fact that many authorities consider that as a means of securing dilatation of the cervix and control of bleeding prior to more efficient treatment, the proper insertion of a cervical and vaginal tampon is a valuable procedure. It is certainly likely to be more generally adopted than the author's piece of laminaria tent. Nor will everyone agree with the author's assertion that in the treatment of eclampsia, active interference for the termination of pregnancy is advisable in no circumstances.

The illustrations are good and adequate, but those depicting wooden handled instruments should be replaced. The feature of this book which will appeal to the practical minded reader is its conciseness; the complications of midwifery are considered as actualities and not as vague contingencies. The freedom from barren theorising and the absence of the unnecessarily profuse illustrations which mar the modern text-book enabled the publishers to produce a volume of a convenient size and at a moderate price.

The second edition of Berkeley and Bonney's "Textbook of Gynæcological Surgery" is announced for early publication by the House of Cassell. Considerable expansion was required to bring the book into line with the authors' present practice, and upwards of one hundred new illustrations, from drawings by Dr. Dupuy, have been inserted, bringing up the number to 489, in addition to 16 colour plates.

Football.

GUY'S v. CATFORD BRIDGE.

Several of our First XV. were away for this match at Bellingham, on Saturday, January 31st. Doherty was playing in the International trials in Ireland, and one notes with regret that for the moment he has not been chosen for the Irish XV. to play against England. The home country may congratulate itself that Ireland does not at the moment avail itself of so good a forward. Ireland must be rich in forwards if they have eight better scrimmagers. J. A. Krige was a reserve at Twickenham, and Bekker, Graham, Davies, Reitz, Steyn, and Olivier were all away as well. The Cup Ties are almost upon us and one would like to see our best men playing regularly together now till they are over. H. Millett at last gets a well-earned cap; if a little late in his career, he may console himself with the fact that it is long overdue

With all this talent off-duty, the remaining players did well to beat Catford by 1 goal 6 tries to nil, and congratulations are due to the "A" team who, after filling up the gaps in the first team, managed to beat Westcombe Park handsomely in the first round of the Kent Challenge Cup. P. J. Krige turned out

at Bellingham; a fine example of pluck and keenness. Splendidly he played, and he had a hand in all the tries except the first, which was gained by Sprong dashing through the mud and scoring in the corner. Krige himself got the second try, and after half-time Krige dashed in with a very fine effort. The Catford team were fine tacklers, no doubt, but in this they were greatly helped by the greasy nature of the ground. Also, be it said, the referee was rather down on us; the whistle was monotonously frequent.

Delightful passing brought a couple of tries from Williams, Van Schalkwijk getting his line away cleverly on both occasions. Our forwards were rather slack, Watson, Neser, and Marais excepted. Watson worked with a will, and for the second Saturday in succession showed great form. Kidman did much hard and useful work; the others were not so good as usual. Daneel was the next to score, and the last try-getter was Seward. Sprong still runs into the midst of a heap of forwards instead of letting the ball out as he should, but his defence is excellent. Seldom has such excellent passing been accomplished even with a dry ball; with the leather covered in greasy mud the handling in this match reached a very high standard. Guy's, 1 goal 6 tries. Catford nil. Guy's Team :—

A. L. Mackay, H. K. Williams, A. Daneel, P. J. Krige, E. C. Seward, J. Van Schalkwijk, E. L. Sprong, G. E. Kidman, A. Marais, A. H. Shellswell, L. K. Watson, E. E. Neser, A. H. Van Zijl, A. Pauw, R. R. F. Duncan.

GUY'S v. ST. MARY'S.

1st Round. United Hospitals' Challenge Cup.

At Richmond, on Thursday, February 5th, in the above competition we beat the St. Mary's team by 5 goals (1 dropped) and 5 tries (39 points) to St. Mary's 1 try (3 points).

The daily papers, sporting and otherwise, do not give quite a correct account of what we really accomplished. We had practically 14 men from the first kick, as Steyn's leg gave way before he had indulged in even a trot; a thoroughly disheartening episode, as J. A. Krige had no wing for the first half to rely on at all. Then just before half-time Marais was carried off, concussed. This was hard luck, as Marais is always good and puts in all he knows, all the time. In the second half, Olivier came up as Krige's wing and Steyn went full back.

About five minutes after play had commenced, Daneel opened the score sheet after good passing. J. A. Krige then got a couple of tries, and right well he played all through. Van Schalkwijk goaled the first try of Krige's. Marais was the next to get over the line. Bekker then added a try, and before half-time, Van Schalkwijk went in very smartly, and converted this try himself. The interval arrived with Guy's leading by 2 goals and 4 tries to nil.

Soon after resuming, and with the game constantly in Mary's 25, our men swarmed on Mary's line, but our opponents were no mean tacklers, and at this stage put in all the defence they knew; no one can say but what they took their gruel jolly well; we were heavier, but they made up for lack of weight by an excess of pluck. Van Schalkwijk was soon over the line again, and he converted this try as well as another from Daneel, who ran in from midfield handing off many opponents and sailing in after a great effort. Between these tries, to introduce variety, J. A. Krige dropped a neat goal. Our last score came from Duncan, who got in from a line-out. Then Mary's had a turn, Roberts taking a long and good shot at goal from a penalty, and Lewis ending up a good afternoon's work by getting a try, just before no side was sounded. May one congratulate Richards, the full back of Mary's, E. L. Reason, and G. R. Davies on their perpetual efforts to stem the tide of misfortune? Till the very end St. Mary's tried, and their last kick was as full of spirit as their first.

Guy's Team.—W. Olivier, A. Daneel, J. A. Krige, P. J. Krige, G. L. Steyn, F. Bekker, G. Van Schalkwijk, W. D. Doherty, G. E. Kidman, F. W. Reitz, A. H. Shellswell, E. E. Neser, A. Marais, R. R. F. Duncan, A. Van Zijl.

Remarks.—Olivier as a full back has all the makings of a great player; in this match he had little to do, but did his full back's job well. The two Krige's and Daneel were very sound, and one is very glad to find P. J. keeping fit; so good a sportsman deserves good luck. Neither Bekker nor Van Schalkwijk have ever played better; the latter was great; Bekker still tries burying himself or burrowing through too often. There was one forward, not a light weight, who scarcely did his whack; the other seven were splendid and Doherty's leadership was the real proper thing.

GUY'S v. LONDON WELSH.

Somehow, one rather thought this would not be a very pleasant match at Herne Hill on Saturday, the 7th February. The ground was in a very heavy state and we had the sun full in our faces for a start. To make things more pleasant still, a thoughtful resident with a garden bordering on the field and behind the end the Welsh were defending, lit a fire made of weeds and waste as soon as the ball was kicked off, and the heavy smoke made things most unpleasant. It was good to hear so many Guy's supporters giving forth encouragement. The Rugby spirit is flourishing, and so it should such a team.

We beat the Welshmen by 1 goal 3 tries, 14 points, to nil. It is a good job Guy's did not score again, or

the Welsh full back would have lost his reason completely. As it was, with every recurring try he got more angry, and his annoyance with the Kriges for playing well and getting near him was profound, if apparently difficult for an ordinary looker on to understand.

Great play by Guy's forwards kept Guy's well placed all through the first half, but only one try came our way and that the result of a fine run by Van Schalkwijk. He converted himself very neatly. We had a good deal of the ball, but I think the centres were running too obliquely; mind you, it was most difficult on Saturday to run at all with the ground so bad.

The second half found Guy's pack still very much on top; every man played well, and frequently the ball was heeled, for our backs to do clever things with, but the heavy going favoured defence. Daneel and Shaw both made good attempts, but Van Schalkwijk was the next scorer. He took a penalty, and cleverly kicked a little bit on and dashed after it for a try; Neser just missed the goal. Good passing and a couple of fine runs by the backs resulted in J. A. Krige handing to Daneel on the line. This time Neser's shot was not so good. Shellswell and Doherty were the best of the pack. With play in the Welsh 25, we had two penalty shots. Neither was successful; our goal kicking is weak. The backs, who got off again from Bekker and Van Schalkwijk's smartness, were almost over again, but just failed, and Zondagh picking up, grounded by the upright.. This time Van Schalkwijk's kick at goal was accurate, but touched by an opponent. The end came with score as above stated. It is a pity the sporting spirit is not more evident among certain teams. A game worthy of the name should be one of give and take, not one wanting all the meat and barking for the bone as well.

Guy's Team.—W. Olivier, A. Daneel, J. A. Krige, P. J. Krige, T. A. Shaw, F. Bekker, G. Van Schalkwijk, W. D. Doherty, G. E. Kidman, F. W. Reitz, A. H. Shellswell, E. E. Neser, R. R. F. Duncan, A. H. Van Zijl, G. Zondagh.

GUY'S v. OLD ALLEYNIANS.

The proceeds of the gate and stand were given to St. Dunstan's Hostel for the Blind, and over £30 was taken for this laudable cause, at Honor Oak Park on Saturday, February 14th. Doherty, Marais, Neser, and Steyn were away from the side. The ground was dry and everything in favour of a fast game, and this undoubtedly took place. The ball frequently came out on our side of the scrum enabling Bekker and Van Schalkwijk to get their backs frequently on the move, and to good purpose, as J. A. Krige quickly got a try. Just after, splendid passing sent P. J. Krige in, and ere long Van Schalkwijk ran in himself with a very clever effort. Finding his way crowded, he doubled and ran diagnoally in the direct opposite direction. A little later the ball was passed to Daneel, who corkscrewed through many opponents, eventually loosing the ball for Reitz to gain the try. This try Van Schalkwijk converted.

The second half had scarcely commenced before J. A. Krige put on two more tries. The second one was obtained from a pass by Bekker to Van Schalkwijk, who found himself with only the full back to pass and three Guy's men on his left. J. A. Krige received and went over. Reitz failed to convert this try; the former one he goaled with a very fine kick from the touch line. For some little time no more tries were registered, and during this period the ball was flung about without proper care. However, no great harm was done. Olivier, at full back, was in his best form, and it is good to notice his constant improvement. Olivier is as good a back as any now playing in London. The next try came from Van Zijl, who all through played well, and the fourth one scored this second half was by Shellswell. Shellswell, Reitz, and Duncan all played well, and Pauw was very prominent with some clever work. Watson was, as usual, untiring. Kidman was in all the heavy work and was, therefore, less prominent from the touch line.

Graham-Davies and J. A. Krige got on well; the former seemed prone to fling his passes to P. J. Krige too far back, evidently thinking P. J. would be more in the rear; but that will soon right itself. Davies ran beautifully straight, even if the leather was elusive. All were glad to see him back in the team and hope good luck will attend him to the session's end. W. D. Doherty played for Ireland on the date under notice; hearty congratulations. The Guy's captain's honour has caused great satisfaction. Final score: Guy's, 2 goals 6 tries, 28 points; Old Alleynians, nil.

Guy's Team.—W. Olivier, P. J. Krige, H. Graham-Davies, A. Daneel, F. Bekker, G. Van Schalkwijk, F. W. Reitz, G. E. Kidman, A. H. Shellswell, L. K. Watson, H. Van Zijl, R. R. F. Duncan, A. Pauw, G. Zondagh.

GUY'S "A" v. NEST. ANGLO F. C.

Played at Elmer's End on Saturday, February 14th, by kind invitation of the Nestle's Milk Co. Guy's sent a strong Second XI. to Elmers End to play a charity match for the funds of this Hospital. Messrs. Nestle's are to be congratulated upon their splendid efforts to augment the funds of Guy's; as a result of this match it is estimated that nearly £25 has been raised.

The match from start to finish was typical of the sportsmanship existing between the two elevens, and although beaten by 5 goals to 1, Nestle's never gave up hope.

Strengthened by the inclusion of six first eleven players, Guy's "A" gave a delightful exhibition and fully deserved their victory.

The home team commenced in a very determined way and for the first ten minutes literally overwhelmed the visitors. However, after this brief attack Guy's settled down and took up the offensive, with the result that Trott broke through and scored. Just before half-time Trott again scored as the result of good forward work by Lindsey, Trott, and Pengelly. Half-time: Guy's, 2; Nestle's, 0.

Within two minutes after the resumption the home side made a fierce onslaught upon Guy's goal and scored their only goal. Following this reverse Guy's took matters into their own hands and for the rest of the game the issue was never in doubt. Further goals followed from Rowbotham; Smith, who in a brilliant solo effort tricked four players, and scored number four; and Van Geuns secured the final goal from a very difficult angle on the right wing.

Remarks.—Pengelly, at centre forward, played an almost perfect game and led his forwards splendidly. Of the remaining forwards, Trott and Lindsey stood out very prominently. The halves were fair and should watch their inside men more closely. Wakeford played a sound game as right back, and Mackeith, in goal, made some very good saves, but kicked poorly.

GUY'S v. ONGAR TOWN.

Played at Honor Oak Park on Saturday, January 31st. For the first time this season, Guy's were able to place a full team against such formidable opponents. As a result, the home team were able to give a very good account of themselves, and gave a sparkling exhibition from start to finish. It was a very clean game, and it is noteworthy that there was only one free-kick given.

The forwards very quickly realised the weakness in the visitors' defence, and but for the sturdy fight put up by Ongar Town's backs and goal-keeper, a much heavier score must have resulted. Ongar's halves were practically useless. The home forwards and halves combined very effectively and kept the play in the visitors' half for the greater part of the game. There was very little work for the backs, chiefly due to the effectiveness of the halves—Rayner, Couch, and O'Meara. The inside men were good, and although Coxon had bad luck with several shots, he made amends with a brilliant goal scored from 30 yards out. Guy's won comfortably by 4 goals to 1.

GUY'S v. ST. BARTHOLOMEW'S.

1st Round of Inter-Hospital Cup.

This match was played at Honor Oak Park on Saturday, February 7th, and resulted in a win for Guy's by 6 goals to 2.

We were unlucky in being without Coxon in this match. Couch took his place as centre forward, and M. T. Wallis came into the half-back line. On a sticky ground, and with the setting sun full in their eyes, Guy's did not make a promising start. At no time during the first half was the standard of football high, though it was keenly contested. Bart.'s had distinctly more of the game, and on several occasions our goal was threatened. Hore, in goal, however, saved well, and only once did the opposing forwards score. The Bart.'s left wing on several occasions beat our defence, and Guy's were lucky on change of ends to be only 1 goal down.

In the second half Bart.'s started off with a great rush and after a scrimmage in front of our goal, scored. The team was now "up against it," and our forwards worked very hard to bring the game level. After fifteen minutes of persistent attack and gradually increasing combination, Couch scored. This acted like magic. After this the whole nature of the game changed. A few supporters now appeared on the scene, they cheered lustily, and there is no doubt that this fact contributed not a little to the change which came over the game. The team was not slow in responding, and in less than half an hour scored six goals in rapid succession. The forwards completely took the game into their own hands and so effectively mastered the opposing defence that the Bart.'s attack did not get another single chance to develop.

After a bad start this was a wonderful recovery, but in the remaining rounds the form displayed in the last half hour of this game will have to be maintained from start to finish, and this can only be done if every member of the XI. is about twice as fit as at present.

The result of Guy's v. St. Thomas's in the Semi-final of the Association Football Inter-Hospital Cup is as follows:—Guy's, 3 goals; St. Thomas's, 1.

Births.

CONES.—At Srinagar, Kashmir, on July 11th, 1919, the wife (née Tyler-Cove) of Capt. H. M. Cones (Indian Police, M.E.F.) of a daughter (Ruth Aileen).

SANDER.—On Tuesday, February 10th, to Mr. and Mrs. E. H. L. Sander, of 20, Holmwood Gardens, Brixton Hill, a son.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE wish to call the particular attention of all Guy's men to the next election to the Council of the Royal College of Surgeons, which is to take place in the first week in July. At the present time we have only one representative on the Council, namely, Sir Charters J. Symonds, who, however, is no longer a member of the active Staff of the Hospital. It must be apparent to everyone that it is a matter of the very greatest importance that such a large Hospital and Medical School as ours should be fully represented on this important body, and not only from the point of view of our own interests as a School, but also for the benefit of medical education, as a whole, it is greatly to be desired that we should have a full voice in the Councils of the College in the many important matters which are likely to come before it in the immediate future.

The Guy's candidate at the forthcoming election is to be Mr. F. J. Steward. All who know his work, both as a teacher, a surgeon and member of many committees at the Hospital, will realise at once his outstanding fitness for the duties which we trust he may be called on to undertake, and we feel sure that all Guy's men will join us in wishing him every success and in looking for his return at the head of the poll.

Good wishes, however, of which he is assured, are not enough, and what we would earnestly ask is for all Guy's men to unite in a determined effort to carry their wishes into practical effect. The voting papers are, we understand, to be sent out towards the end of this month, so that it is necessary for those who are going to help, to do so at once. The ways in which the result which we all hope for can be assured are several. In the first place, of course, all Fellows of the College should give Mr. Steward a vote, although it is by no means necessarily desirable that they should give him *all* their votes, or, in other words, "plump" for him. Fellows are extremely likely to be asked to give a vote to other candidates from other Schools, and such votes, if given on the definite basis of a quid pro quo can serve a very useful purpose in securing additional votes from outside sources for the Guy's candidate.

In the second place, all Guy's men, whether they are Fellows or not, can very materially influence the result of the election, although they may have no actual vote themselves. What we would ask them to do is to make a point of personally interviewing or writing to all the Fellows of their acquaintance in their neighbourhood or elsewhere and of securing the de-

finite promise of a vote for Mr. Steward. If only all Guy's men will make a determined effort on these lines, *and make it soon*, there should be little doubt of the result we all so heartily desire being successfully accomplished.

We understand that there has been a good deal of heart burning in a certain Department of the Hospital owing to the suggestion that the amount of Dental Caries in a given district is directly proportional (a) to the number of Dental practitioners, and (b) to the number of toothbrushes in use in that district, the idea being that dental caries is more of the nature of a deficiency disease, due to the absence of substances of the order of fat soluble A and water soluble B. People who hold this latter view consider that antiseptic mouth washes are all more or less futile, and they strongly deprecate the vigorous use of the toothbrush twice daily. Altogether, there seems to be a sound physiological basis to the theorising of the anti-toothbrush brigade; nevertheless, we do not think that the world at large are likely to be influenced by their physiological arguments. In any case one would be glad to hear the opinion of the experts on this question.

We were very interested to read of the discussion on "the use of alcohol as a therapeutic agent," which took place at the Royal Society of Medicine recently. Most of the authorities were agreed that alcohol, being an easily assimilated food, is of special use in wasting diseases like phthisis, cancer and diabetes, and also in the convalescence following influenza and the acute fevers.

Indeed, Dr. R. Hutchinson states that: "It was agreed that alcohol was a digestive stimulant; many people take food better with a certain amount of alcohol; with a tired stomach, a glass of wine was a direct aid to digestion." These remarks are in accordance with one's own general experience, and we hope that they have been brought to the attention of the prohibitionist campaigners in this country.

The Executive of the War Memorial has had considerable difficulty in compiling a complete list of all men who have fallen or who have served in the Great War. Accordingly, there has been inserted into this number of the Gazette a detachable form, and it is requested that all concerned will fill in the required details and return the form to the Secretary of the Executive Committee of the War Memorial.

We announce on another page of the Gazette that the First Annual Students' Dinner will be held on March 19th. The tickets are extraordinarily cheap, and the affair will be quite informal; it will be followed by a smoking concert (also informal). In addition, by kind permission of the Nestle's Milk Co., the Nest-Anglo Orchestra, conducted by Mr. F. Hills, will render selections during the evening.

This is the first opportunity of its kind that has occurred since the war, where men of all years can meet and have a jolly good time together. It is to be hoped that as many men as possible will take advantage of this opportunity. As the number of tickets is limited to two hundred, all men who wish to come would be well advised to apply to the President of the Residents—early.

By the victory of the Rugger Team over Thomas's on the 20th February, Guy's is represented in the final of the Rugby Football Cup-Tie, as well as in the match for the Soccer Cup. We wish the teams the very best of luck and look forward to seeing both Cups down in the Smoking Room once again.

We have no doubt that crowds of men will turn up to cheer Guy's against Bart.'s. The Soccer Team, however, is by no means so certain of support. Yet, it is the cheers and enthusiasm of its supporters which more than anything else stimulates a team to play at the very top of its form. As Guy's men, we wish to see the Hospital "top dog" at work and play, and one hopes that all men who can possibly spare the time will make a special effort to turn up on 10 . 3 . 20, when Guy's are playing London Hospital.

We were very sorry to hear that the Captain of the Soccer Team, G. P. Lindsay, fractured his leg in the match against Thomas's. We wish him a speedy recovery.

One would have thought that the verdict of Paisley, and the opinion of a man like Lord Robert Cecil, would have convinced the average man that, after all, it was no bad thing for the country that Mr. Asquith had been returned once more to the House. It was with considerable annoyance and regret, therefore, that one read of the disgraceful rag that marked the dedeparture of Mr. Asquith for the House of Commons the other day, and it is comforting to think that Guy's, at least (contrary to the statement made in one of the evening papers), took no part in the rag, as far as we know.

At the time of the Pussyfoot affair—for which there was some justification—there was a general feeling abroad that the medical students were going perilously near the dividing line between a mere rag and what constitutes downright hooliganism.

The free fight round the ex-Premier's car, containing Mr. and Mrs. Asquith and Lady Bonham-Carter, was utterly unjustifiable; not only does it show an absolute lack of appreciation of true greatness, but it demonstrates an apparent ignorance of the most elementary tenets of good form that is almost unbelievable.

A rag, so long as it is confined to rival hospitals, or is directed against some absurd and interfering crank, is well worthy of support; it does the raggers no harm, it amuses the general public, and provides copy for the newspapers.

When, however, a body of men — whoever they may be—take it into their heads to annoy publicly so eminent and worthy a man as Mr. Asquith it is time for the competent authorities to take the matter in hand and put a stop to the proceedings.

Guy's Hospital Reports.

War Memorial Volume.

As part of the scheme for the commemoration of men who have fallen or who have served in the war, it has been decided to publish a volume of the "Guy's Hospital Reports" as a memorial volume.

This will contain photographs and obituary notices of those who have lost their lives whilst on active service, and also a record of all Guy's men and nurses who have served with His Majesty's Forces.

There has been great difficulty in compiling such a record, and in order that this record may be as complete as possible, members of Guy's are requested to fill up the enclosed form and return to the Honorary Secretary, Executive Committee War Memorial Fund, Medical School, Guy's Hospital, S.E.1, on or before Monday, March 15th, 1920.

Guy's Hospital Annual Dance.

The Guy's Hospital Annual Dance will be held at Prince's Galleries on Wednesday, April 21st. Dancing from 9 p.m. till 3 a.m. Tickets £1 1s. each (supper included). Maurice van Stratum's Orchestra from Moon's Club has been obtained. Tickets may be obtained from members of the Committee or the Hon. Secretary, W. H. Cellier.

Some of my Experiences of the War.

By C. HIGGENS, F.R.C.S.,
Consulting Ophthalmic Surgeon to Guy's Hospital.

In August, 1914, I wrote to the Secretaries of the War Office and the Admiralty offering my services in any capacity in which they could employ me. I received the usual polite official reply which amounted to an intimation that they had no use for old crocks.

I then joined the Special Constabulary which appeared to be the only thing I was qualified for, and even the Inspector at Vine Street smiled when I gave my age, but was good enough to say there was one on the list older. Later I was duly sworn in with a number of others, most of whom I was thoroughly ashamed of, for they were young men obviously joining the Specials in order to avoid military service. I do not wonder at the Regular Police striking, for of all the dull jobs I have ever had, a special constable's is the worst. I remained in the Police eighteen months and was a sergeant for the last year.

But something came out of the Police business. It happened in this way: I was on duty at the Electric Light Works in Davies Street one morning when I met Sir Arbuthnot Lane; he said, "What on earth are you wasting your time on a job like this for?" I replied that it was the best I could do; he said, "Nonsense, write to Callender at No. 2 Hospital and ask him to appoint you ophthalmic surgeon there."

I wrote to Colonel Callender and asked him to appoint me ophthalmic surgeon to the hospital. I told him that I had got the sack from Guy's eight years before for old age and imbecility. He answered, thanking me for my letter, and said, "I am well aware that you neither suffer by reason of old age or imbecility, and shall be sorry for the prisoner who thinks he can safely asault a special constable when you have him in charge. But my orders are quite explicit and are to the effect that I may recommend no one for a commission upon the a la suite list of this Unit who is not upon the active staff of Guy's, St. Thomas's, or London." (Mr. Ormond was appointed at No. 2.)

After he was appointed he wrote to me and said he had been offered a post at a small hospital at Epsom of about 270 beds and advised me to inquire about it, which I did, and found that it was the County of London War Hospital with 270 beds.

It was being opened, and I went there and saw the officer commanding and got the appointment of Ophthalmic Surgeon. There were then no patients in the hospital and no staff to speak of; I set to work and helped the C.O. to get a staff together and commenced work myself in April, 1915. At first I had very little to do, and it was of the nature of Civil Hospital Out-Patients' work. But it seemed to me likely that I might in the future have to do anything in the way of surgery, so I spent my spare time in doing two courses of operative surgery and worrying poor old Bell by constant appearances in the post-mortem room for the purpose of hacking about his charges.

As time went on I began to get pretty busy at Epsom; the Out-Patient practice increased. Patients came from far and near; there were several camps in the neighbourhood, and their medical officers never seemed to think it necessary to do anything for eye cases. The consequence was, I was deluged with trivial cases and anomalies of refraction. Often three or four captains would come, each bringing half a dozen or more cases of astigmatism, and all wanting to be attended to first. I need not say that state of things did not last long. I did all I could for a fortnight and then went to the C.O. and told him I would not do it any more. So he wrote to the C.O.'s of sundry camps and pointed out to them that if they wanted those sort of cases attended to they must get it done in their own places; I was not troubled with them any more.

I went on doing whatever there was to do in the way of operations and cases of eye disease, with a few refractions, and had quite an easy time. Later the authorities thought that the Out-Patient work which I had declined to do, should be taken up again, so a resident Ophthalmic Surgeon was appointed—Captain Mason; and before going further I wish to say that a more thoroughly competent, hard-working and agreeable colleague I could not have had, to say nothing of his being one of the best fellows possible. The same remarks apply to his successor, Captain McHoul, who has now been with me about six months.

In addition to Captain Mason, one, and later a second army optician was appointed. The

Out-Patients came again from camps and other hospitals for miles around and their number became enormous—about ten thousand a year, but Captain Mason and his two optician assistants were able to cope with them, and things went on swimmingly and have continued to do so ever since; we have never had a hitch of any kind.

In August, 1915, my own work which was chiefly operative began to increase, and not very long after, the Hospital (or myself) was made the centre to which all the one-eyed men who came into the Eastern Command had to be sent.

They soon began to arrive in numbers and kept me busy. For three years I did anything from three or four or more hours operating two days a week—my record was over ten—from 10 a.m. till 8.30 p.m., with a twenty-minute interval for lunch. I slept calmly in the train that night for twenty-five minutes after it arrived at Waterloo.

My business was to see that all one-eyed men were set up with an artificial eye. A considerable number of them had good sockets, and could easily be fitted, it was simply a matter of selecting an eye from a large stock which matched the sound one as nearly as possible; this was done in many cases, but in many more the right eye could not be found—if it was the right colour it was not the right size, and vice versa; but if an eye the right size could be found and another, the right colour, the two were sent to the Army Spectacle depôt, where a very large stock was kept, and a combination of the two was returned to the Hospital. We have fitted over 3,000 eyes. My patients presented instances of every kind of injury and disfigurement of the upper part of the face; it would be impossible to describe them all.

There were torn eyelids united anywhere except where they should have been; many destroyed in whole or in part, hideous depressed scars, smashed noses, scars going through the cheeks and laying open the cavity of the mouth, malar bones knocked in, orbital margins broken away, antra laid open and jaws fractured, to say nothing of fractured skulls—all of which came under my care. I have not been very successful with my brain cases; they were all old fractures with sinuses leading to the interior of the skull, which I left severely alone, unless they got brain symptoms, which four of them did. I removed the bone in each of these cases and came on to pus, which I drained. Three of the cases got cerebral hernia and died; one recovered.

Then there were a great many cases of foreign bodies lodged in all parts of the face and at varying depths from the surface. The men always described them as shrapnel, but there was a good deal of difference in their nature. They varied much in size and shape: some of them were quite large chunks of thick metal, others quite thin; there were bits of wire, nails, and in one case I removed a small short cylinder with a disc at each end, like a reel for winding cotton on; the man told me it was part of the fuse of a whizzbang. There were some bullets, but not many; as one of the men once described it to me, "they were non-stops." I look upon a bullet as a gentleman; unless he has got turned over or interfered with in some way, he does not injure any vital part, but makes a nice clean wound which heals very quickly. I remember two cases in which a bullet had entered just below the malar bone in front of the coronoid process of the jaw, passed through the upper part of the antrum and the nasal cavity, and emerged just beneath the inner angle of the orbit opposite without doing any damage. There were just two small punctures and a certain amount of bleeding from the nose; they both recovered entirely. Inside a week I had another case under observation for some time. It was that of a man who was sent to me for headache. He had a scar, said to be a bullet wound, about the posterior superior angle of the right parietal bone, and there was no wound of exit. An X-ray photograph showed the bullet apparently lying on the falx cerebri, its base about an inch inside the back of the skull and its point forwards. I kept the man under observation for some weeks and went so far as to rehearse an operation for its removal in the post-mortem room. I opened the skull and got Bell to plant a bullet on the brain without my seeing where he put it. I found it without much difficulty.

I never had to do the operation, the man got rid of his headache and left the hospital; I never heard of him again.

All injuries in which the presence of a foreign body was suspected were X-rayed, there was no hunting about for them until their position was fairly well indicated, and the uninitiated on seeing the bright shining object plainly defined in the negative, would think there could be no difficulty in removing it. He would soon find out to his cost that such was not the case.

I have removed a great many; some were simple, especially if they were not very deeply embedded, but others have taken me an hour or more searching for them, and in some cases I have failed entirely, and a second X-ray examination showed them to be exactly in their original position. Such, unless they are causing trouble, are better left alone.

Most of the foreign bodies I have removed have been lodged in or near the orbit, and were generally not difficult to find. But there is an area bounded in front by the outer margin of the orbit, below by the ramus, coronoid process, sigmoid notch and condyle of the jaw, behind by the auditory meatus, the root of the zygoma and lower part of the temporal ridge, and above by the temporal ridge. A foreign body entering in this area has unlimited facilities for hiding itself. It can get inside the zygoma or condyle or coronoid process, probably causing a fracture, or through soft parts above the zygoma, or below it through the sigmoid notch, or behind, below the condyle of the jaw, between it and the mastoid process and lodge anywhere beyond. They may have partly entered the skull or be lying against it, may have passed beneath the temporal bone and be fixed against the pterygoid processes or even, if small, gone across the middle line and be fixed in the bones at the base of the skull. A large foreign body taking this course would probably place the patient beyond the need for an operation. Some get lodged about the condyle of the jaw and interfere with its movements and may damage the facial nerve close to its exit from the skull. I have twice hunted for a foreign body in this position and failed to find it.

Others get into the antrum, back of the orbit, nasal passage, or lodge less deeply in the soft parts occupying the area defined above; all, unless of fair size, are difficult to find. My method, and a fairly successful one for locating them, is by probing with a good-sized suture needle in the position indicated by the X-ray plate. If the needle comes on bone and is pressed firmly on it, it sticks in, but if it strikes the foreign body it stops dead, and on withdrawal its point is turned. At one time I had a very fine drill given me by a dentist; it would go through bone easily, and only stopped when it came to the foreign body, and was much better and much more reliable than the needle, but a colleague borrowed it and I have never seen it since, nor have I been able to get another.

(*To be continued.*)

Locking the Stable Door.

The "Suggestions for the Control of Venereal Disease" from the Medical Women's Federation—whoever they may be—seem to call for some comment even at this belated stage of the controversy. Indeed, one cannot help being reminded by the war which has raged in the medical press, of the Jew who was disturbed at breakfast by a terrific thunderstorm. "Lord!" he said, "what a fuss to make about a little bit of bacon!" The antiprophylaxionists (if I may be pardoned for adding yet another hideous word to the language) base their opposition, seemingly, on two main objections: (1) That the possession of a tube of calomel cream or whatnot will drive men to vice, and (2) That this so-called preventive treatment is in reality no protection at all, but, rather, its possession is invariably accompanied by a rise in the rate of venereal admissions. A third, and somewhat subsidiary clause, is that any State action in the matter is equivalent to the authorisation of sexual irregularities.

So strongly in fact do the Medical Women feel upon the first point, that, in language reminiscent perhaps of the Lyceum, they affirm "that a phase of society would be produced as vicious and degenerate as any of which history has record . . . moral degeneration and sex excesses would rot the very foundation of society." In Heaven's name, Why? Condoms are to be obtained at every chemist's, and other appliances even less elegant are exposed to the public gaze, yet the only person ever known to complain thereof was the ex-Kaiser, who feared their use would prevent the birth of adequate supplies of cannon fodder.

Syphilis, as is well known, was not introduced into Europe till 1493. What were the foundations of society doing up till then? In rural Ireland, where venereal disease is unknown, do we find "a phase of society as vicious and degenerate, &c., &c.?" Of course not. Indeed, the point is so obvious that it were needless to labour it.

It seems extraordinary that advocates can be found for this policy of chastity by terrorization. There are, it is true, individuals who maintain a nominal chastity through fear of infection, but unless stronger and higher motives are also present they are only too apt to relapse into practices infinitely more injurious, morally and physically. Anyone with even a moderate experience of this class of work will realize what I mean. Moreover, from the standpoint of pure ethics, one may well ask: Of what value to the individual or to the community is continence of this kind. Its tendency would seem to be exactly that urged against the prophylactic system, that in the search for fresh and presumably uninfected

subjects more and more recruits to vice will be enlisted.

As to the second point, anyone who has had any practical opportunity of observing prophylaxis among men who had all to lose, and nothing to gain, by contracting disease (a point which in my opinion invalidates many of the Army statistics) will have no doubt whatever as to its value. To quote an actual instance. In 1919 a certain flotilla was in the habit of visiting Smyrna and other Eastern Mediterranean ports which are notorious as hotbeds of venereal disease in all forms. On the first occasion prophylactics were not available, and the incidence of disease was literally appalling. Two vessels of a complement of some eighty men could only barely put to sea, and the work of the whole flotilla was seriously handicapped. On a later occasion, when preventives were available, and the men had been instructed in their use, in one ship (typical of many) out of 120 men, there were three cases, two of them leave-breakers who had been absent from the ship for five days, and the third a Maltese steward who did not understand English sufficiently to appreciate the medical officer's lecture. It should be mentioned that the men of this flotilla were receiving special rates of pay, which ceased if they were in hospital with venereal disease, thus affording a very material inducement to avoid disease.

With regard to the alleged increase among Australian troops as a result of prophylaxis, the figures have been deliberately misquoted by the National Council, as is shown by Mr. Wansey Bayley in the *British Medical Journal* of February 7th, 1920. Thus in France in the quarter ending September 30th, 1917, the annual admission rate per 1,000 was 101, and in England 167. By September 30th, 1918, these figures had fallen to 55, and 132 respectively, followed in the last quarter of the year by a slight rise owing to shortage of medicaments and the disorganisation consequent on demobilisation. The higher figures for England were due, as Mr. Bayley points out, to the fact that "although we had a good system, we did not provide adequate means for carrying out . . . The New Zealand Division's experience corroborated that of the Australian divisions—namely, that 60 per cent. of the infections came from London, and that with the development of disinfection achieved in France we were within measurable distance of reducing venereal disease to a negligible quantity."

It is a fine point to distinguish between early State treatment of the disease when it has manifested itself and preventive treatment before it has developed. One would have thought that State provision of any kind would have been tantamount to recognising the disease was inevitable—as under existing social conditions it is—and once you had overcome the opposition to providing free and secret treatment, free and secret prophylaxis was a logical sequel. But the old theories of crime and punishment die hard. "The gods are just and of our pleasant vices make instruments to scourge us." Only recently one heard of a practitioner who refused to treat syphilis on this ground, and though one may deplore his standpoint, one cannot but laud his consistency.

The truth of the matter is that the medical profession, as such, are not, or should not be, concerned with morality. That they deplore vice, private or public, does not touch their position as preventers and healers of disease. If this were not so, the doctor might well be justified in a minute enquiry as to the circumstances of any infection, and refuse to treat it if they did not meet with his entire approval. And so, in this instance, we are not asked whether or no disinfection after sexual intercourse is likely to result in "red ruin and the breaking up of laws," but whether such disinfection will prevent a man inflicting irreparable damage on his wife and his unborn children. To that question our answer is "Yes."

Other points raised in the manifesto strike one as almost fantastic in their illogicality. There is the case of the prostitute convicted at Marylebone Street Police Court on the evidence of a medical officer of conveying venereal disease. This, we are told, "would certainly deter patients from seeking treatment and lead to concealment of disease." Why? If the infected prostitute is to be allowed to carry on her business although she is fully aware of her disorder, the time of the doctor and the money of the State are being wasted in her treatment. Actually, of course, she is concealing disease, and that, from the persons most concerned by it.

With the constructive policy of the Committee I am, happily, in entire agreement, but, alas, the millenium is not yet, and we have to make the best of a sadly imperfect world. Prostitution is still with us, and will continue to be so long as the wages, for instance, of the "lady clerk" average in London 35s. per week. The economics of the matter is an interesting subject, but space does not allow me to touch on it here. Those who wish, will find a brief review of the question in an article entitled "The Living Wage" in the GAZETTE of October 7th, 1916.

Finally, let me emphasise that the worst possible way of approaching this, or indeed any other problem, is the sentimental way. For two thousand years we have romanticized and sentimentalized over our Saphos, our Messalinas, and our Magdalenes, and for precisely that reason syphilis has filled the asylums of Europe, and gonorrhœa has sent potential mothers childless to the grave.

I am almost tempted to quote the immortal words of the Napoleon of Notting Hill—but perhaps some of my readers know them already.

G.H.F.G.

Standardizing the Conception of Cardio-Vascular Depression.*

Speaking before a joint meeting of the American Association of Obstetricians and Gynæcologists at the Interstate Association of Anæsthetists, at Cincinnati, on September 15th, 1919, Drs. Charles W. Moots and E. I. McKesson emphasised the fact that cardio-vascular depression being the outstanding symptom of the condition known as shock, it is reasonable to start with the proposition that whatever means enable us to determine the very beginning of this condition is of the greatest importance. These authorities hold that:

"When a cardio-vascular system is reacting normally, an increased pulse rate is accompanied by an increased systolic and diastolic blood pressure, and vice-versa. The pulse pressure is roughly half as great as the diastolic pressure and is the most direct evidence we have of the amplitude of the heart contraction—the best evidence of effective blood movement. In normal sleep, the pulse rate and blood pressures are lowered but their normal relationships are maintained; so are they in an ideal anæsthesia.

But during surgical operations, so many factors enter to disturb the normal reaction of the circulation, that we may have many combinations, with almost never a true stimulation, but very frequently a depression of the circulatory system. The changes occur so frequently with sometimes disastrous and sometimes innocent results, that it is most desirable to be able to differentiate between them and to anticipate their onset.

Blood Pressure Rules.

There is no form of anæsthesia, there is no age of patient, there is no type of operation, in which one expects to see an elevation of blood pressures during the operation. Our fears are from low blood pressures, rapid pulse rate, and heart fatigue.

Circulatory Depression or Decompensation is best divided for surgical operation into three degrees:

Safe.—10 to 15 per cent. increase on pulse rate without change in pressure. 10 to 15 per cent. decrease in blood pressures without change in pulse rate.

Dangerous.—15 to 25 per cent. increase in pulse rate with 15 to 25 per cent. decrease in blood pressures.

Fatal.—Progressively increasing pulse rate above 100 with progressively falling blood pressures of 80 or less systolic and 20 or less pulse pressure, for more than 20 minutes.

The first degree is never fatal, but may gradually merge into the second degree. The second degree, beginning shock, may be regarded as dangerous in the sense that it exhausts the heart and disarms it for defence against continued low blood pressures.

The third degree is always dangerous to the life of the patient. A vicious circle is established, consisting of the low blood pressure, the reduced heart nourishment which in turn still further reduces the blood pressure, and so on progressively. This usually develops within 20 minutes after the third degree depression occurs, and when once well established proves fatal at once or at most within three days. The time in which shock proves fatal depends upon the cardiac muscle reserve and the effectiveness of the treatment employed. Third degree depression may be present in a patient without the usual alarming signs, but after the vicious circle becomes established evidences of shock become well marked.

Value of Blood Pressure Readings.

With the palpating finger, no matter how skilled, one cannot determine all the characteristics of the pulse or the pulse pressures with sufficient accuracy to be of much prognostic value as to the onset and degree of circulatory depression during a surgical operation.

Blood pressure and pulse determinations every few minutes during all of the more serious operations, as well as in many of the so-called minor cases, are a part of the duties of every anæsthetist. The information regarding the patient's fitness for the operation, his reaction to certain procedures and the immediate prognosis can be gained in no other way with the same degree of accuracy.

The procedure is made convenient and easy by fastening the blood pressure cuff to the right arm and snugly binding the stethescope below it with elastic webbing. Readings can then be made at will without disturbing sterile sheets and without losing the continuity of anæsthesia.

Preserving Muscle Tone.

A suitable graphic chart is preferable as a record because the tendencies of the circulation are readily compared from time to time and because the prognosis based upon these tendencies and the character of operative work to follow, can be more accurately made.

Where nitrous oxide-oxygen was available in skilled hands, the war has corroborated our previous observations that this form of narcosis is one of the best shock prophylactics we have.

It is not remarkable that nitrous oxide-oxygen should be safer in shock and in preventing shock than other anæsthetics when one recalls the fact that muscle cannot be paralysed with it.

The greatest responsibility of the anæsthetist is to avoid relative over-dosing of the patient in an effort

*Communicated to the Gazette by the National Anæsthetic Research Society of America [Ed.].

to please the surgeon, who may be demanding a flabby musculature.

The relaxation is not confined to striated muscles of the abdomen and extremities, but extends to the striated muscle of the heart. The effect is at once reflected by the pulse pressure, and if pushed too far the diastolic pressure is also decreased showing the action upon smooth muscle as well.

The clinical study of blood pressure has convinced us that the final factor in shock is muscular exhaustion or an interference with muscular action. One thing is most apparent, the average patient having been profoundly anæsthetized for extreme relaxation is half shocked, a second degree depression, and it often takes but little trauma to complete the picture of third degree depression.

In this connection it is interesting to report that all the members of the Toledo Society of Anæsthetists have adopted this standardized conception of cardio-vascular depression and are using it graphically on their charts. Their records when compiled should develop some valuable and original information.

A Case of Primary Carcinoma of the Tonsil and Sarcoma of the Scapula in one Individual.

T.L., æt. 46, a worker in asphalt, came to Out-Patients in December last, complaining of weakness and some pain in the right arm.

He gave a good family history, and had no knowledge of any previous illness. When at work during the first week in September he noticed a dull aching pain in his right shoulder and arm as far as the elbow, almost continuous but increasing at night and interfering with his sleep. There was also some slight loss of power.

These symptoms increased in severity slowly until three months later, when the patient complained of some difficulty in deglutition. He was treated for tonsilitis with some success.

On examination he was found to have a smooth stony-hard hemispherical swelling firmly attached to infraspinous fossa of his right scapula, not involving the overlying skin. The glands in the axilla were large and nodular but fairly freely movable. There were one or two isolated hard glands in the supraclavicular fossa on the same side. There was also considerable wasting of nearly the whole musculature of the right arm, with marked limitation of function.

The man's right tonsil was somewhat enlarged, and this enlargement appeared to be of inflammatory origin. Also there was some slight deficiency of air entry at the base of his left lung.

Special examinations revealed:—

1. A negative blood Wassermann reaction.

2. X-ray evidence of great bony destruction in infraspinous fossa of scapula, suggesting sarcoma of inferior angle, possibly of myeloid nature.

3. Loss of all electrical reactions in supra- and infra-spinati muscles; other muscles reacting to Faradism.

A diagnosis of primary sarcoma of the scapula, with possibly secondary deposits in the chest, was made.

As, however, the right tonsil was increasing in size, it was decided to remove it. This was successfully accomplished, and microscopical examination of it revealed a basal squamous-celled carcinoma, probably of primary origin in the tonsil. There was no involvement of glands draining the tonsil region.

Meanwhile, a pleural effusion occurred on the left side and was increasing rapidly. There was also some slight hæmoptosis and cough. At this stage patient was discharged from hospital, as operative treatment was considered inadvisable.

Unfortunately a portion of the scapular tumour was not removed for pathological examination.

Clinically a diagnosis of primary sarcoma of scapula with an incidental primary carcinoma of tonsil seems inevitable, but this combination of two malignant conditions must be infinitely rare.

I am much indebted to Mr. Turner and Mr. Hearne for permission to publish this case.

E. H. RICHARDS.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The following letter has been received by Mr. Curry:—

Nestanglo Sports Club,
Nestle & Anglo-Swiss Condensed Milk Co.,
6 & 8, Eastcheap, E.C.3.
February 27th, 1920.

Mr. W. J. Curry,
Clerk, Guy's Hospital, S.E.1.

Dear Sir,

It is with great pleasure that I enclose herewith cheque value £25 12s. 6d., which represents proceeds of the Charity Match played between our football team and yours on the 14th instant. The game was a good one, and although beaten by a superior team, we thoroughly enjoyed it, and hope to have some further meetings next season.

I trust that this small donation will be of some little assistance to you in carrying out your good work.

Yours faithfully,
(Sgd) MALCOLM A. MAYES,
Hon. Sec., N.F.C.

The financial results of the match are very satisfactory, and Mr. Curry has conveyed the thanks of the Treasurer and Governors to the Committee of the Nestanglo Sports Club.—[Ed.].

Abstract of Summary of Anæsthetics and Operations for the Year 1919.

The number of cases in which general anæsthetics were administered was 7,456, among which were 51 intratracheal insufflations of ether, 1 of chloroform, 1 of gas, 1 of A.C.E., and 3 of ether and C.E. Spinal analgesia was also employed on 39 occasions, and on 44 occasions spinal analgesia followed by a general anæsthetic. The total number of operations was 7,254 in wards (Bright Ward excepted), special departments, out-patient departments, and surgeries. There were five deaths under anæsthesia.

There have been 5,017 cases of general anæsthesia in the Dental Department; 4,540 under nitrous oxide gas, and 477 under ethyl chloride.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the table below showing how many operations are actually performed in these wards:—

Anæsthetics.

A.C.E.	138
C.E.	1044
Chloroform	204
Ether (including gas and ether)	242
Gas, and gas and oxygen	1615
Intratracheal insufflation of ether	52
Intratracheal insufflation of chloroform	1
Intratracheal insufflation of A.C.E.	4
Intratracheal insufflation of ether and C.E.	3
Intrapharyngeal ether	4
Spinal analgesia	39
Spinal analgesia followed by a general anæsthetic	44
Other anæsthetics and sequences	4105
	7495

Administrators of Anæsthetics.

Staff Anæsthetists	1125
Visiting Staff	651
Resident Surgical Officer	88
House-Officers	4855
Other Qualified Men	776
	7495

Operations.

Tabulated According to Wards and Departments.

Astley Cooper	270
Cornelius	267
Lazarus	257
Job	340
Naaman	291
Luke	288
Patience and Samaritan	352
Evelyn	203
Charity	302
Dorcas	345
Lydia	322
Martha	315
Eye Wards	711
Addison	74
Mary	24
Stephen	46
Esther	65
Queen Victoria	446
Miriam	8
Isolation	10
Out-Patients	1877
Front Surgery	373
Back Surgery	63
Nurses' Sick Room	5
	7254

Turning to the general wards, it may be noted that the totals of operations are as follows:—

Surgeons	807
Assistant Surgeons	670
Specialists	74
Resident Surgical Officer	537
House-Surgeons	737
Dressers	382
	3207

The remaining 279 operations, bringing the total up to 3,486, were performed by other operators.

It should be remembered that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 492, of which 215 were performed by the Obstetric Surgeons, 141 by the Obstetric Assistant, 7 by the Gynæcological Assistant, 90 by the Obstetric Residents, while 39 operations were performed by other operators.

The operations upon ophthalmic cases in the wards, number 128, of which 90 were done by the ophthalmic surgeons, 7 by the ophthalmic assistant, 8 by the ophthalmic house-surgeon, 10 by ophthalmic dressers, and 13 by other operators.

There were 623 operations for throat and ear diseases in the wards, 444 by surgeons, 50 by clinical assistants, 59 by the house-surgeon, 49 by dressers, and 21 by other operators.

In the Orthopædic Department 134 operations were performed, 6 by dressers, 113 by the surgeon of the department, 12 by the Orthopædic Registrar, and 3 by other operators.

In the Genito-Urinary Department 55 ward operations were performed, 41 by the surgeon, 5 by the resident surgical officer, 4 by dressers, and 5 by other operators.

In the Venereal Department there were 19 ward operations performed.

Eight operations were performed on patients in beds for skin cases.

In the Front and Back Surgery 436 operations were performed, 4 by the resident surgical officer, 190 by house-surgeons and out-patient officers, 2 by the assistant casualty officer, 229 by dressers, and 11 by other operators.

In the General Out-Patient Department 589 operations were performed, 319 by dressers, 86 by house-surgeons, 3 by surgeons, and 181 by other operators.

In the Special Out-Patient Departments, there were 1,099 operations upon throat and ear cases, of which 178 were done by the surgeon, 113 by the clinical assistant, 66 by the ophthalmic house-surgeon, and 642 by dressers, while 100 were by other operators.

Two operations were performed by the surgeon in the Eye Department.

In the Genito-Urinary Department 2 operations were performed by dressers. One operation was performed by the surgeon in the Obstetric Department, 1 operation by dressers in the Children's Department. In the Orthopædic Department 179 operations were performed, 22 by the surgeon, 16 by the orthopædic registrar, 94 by dressers, and 47 by other operators.

Change of Address.

Surg. Cmdr. Arthur Thomas, O.B.E., F.R.C.S., Ed., R.N., Royal Naval Hospital, S. Queensferry, Scotland.

W. Bernard Secretan, 11, Craven Road, Reading.

Capt. J. York Moore, R.A.M.C., 91, Malden Road, Colchester, Essex.

Dr. G. Dunderdale, M.D.Lond., Pietermaritzburg, Natal, South Africa.

F. J. Cutler, M.R.C.S., Kensington House, Dudley Road, Hastings (Tel. 861).

Owen Richards, C.M.G., D.S.O., M.A., M.D., M.Ch., F.R.C.S., Kass el Ainy House, Cairo, Egypt (permanent).

F. C. Newman, The Oaklands, Knowle, Warwickshire.

C. H. Brangwin, Roebuck Hotel, Buckhurst Hill, Essex.

Arthur Joseph Eagleton, 112, Thurlow Park Road, Dulwich, S.E.

Capt. Horace E. H. Tracy, Civil Hospital, Basra, Mesopotamia.

Papers by Guy's Men.

F. E. Shipway, M.D.: Intratracheal Insufflation of Ether in Operations which involve bleeding into the Air Passages, and Apparatus for Nitrous Oxide, Oxygen and Ether.—*Proc. Royal Soc. Med.*, Dec., 1919.

Geoffrey Marshall, M.B.: Two Types of Portable Gas Oxygen Apparatus.—*Ibid.*

H. C. Cameron, M.D.: (1) Enlargement of Cervical Lymphatic Glands in a Case of Congenital Syphilis. (2) Sudden Occlusion of the Right Brachial and Femoral Arteries in an Infant aged 10 days, with Gangrene of Arms and Leg; Recovery of Arm, Amputation at Thigh.—*Ibid.*

E. Bellingham Smith, M.D.: Splenectomy for Splenomegalic Cirrhosis.—*Ibid.*

H. W. Barber, M.D.: Case of "Erythrodermie Congénitale Ichthyosiforme."—*Ibid.*

W. M. Mollison, M.Ch.: A Case of Latent Double Frontal Sinus Suppuration with Expansion of the Sinuses following a through and through Bullet Wound received Three Years previously.—*Ibid.*

A. F. Hurst, M.D., and W. M. Mollison, M.Ch.: Hysterical Deaf-mutism of Eighteen Years' Duration. —*Ibid.*

W. M. Mollison, M.Ch.: Vertigo in Conjunction with a previous Radical Mastoid Operation.—*Ibid.*

Percival P. Cole, F.R.C.S.: Case of Carcinoma of the Colon after Operation.—*Ibid.*

Thomas D. Lister, C.B.E., M.D.Lond., M.R.C.P. Lond., F.R.C.S.Eng.: Some Aspects of the Tuberculosis Problem.—*Lancet*, Feb. 21st, 1920.

J. Tewfik, M.R.C.S.Eng., L.R.C.P.Lond: A Case of Hirschsprung's Disease, Causing Acute Obstruction.

Philip Turner, M.S., F.R.C.S.: Notes on a Series of 103 Cases of Compound (Gunshot) Fractures of the Femur Treated at a General Hospital in France. —*Lancet*, Feb. 28th, 1920.

The Anatomy of Local Anæsthesia.—*Brit. Dent. Jour.*, March 1st, 1920.

Appointments.

Owen W. Richards, C.M.G., D.S.O., M.A., M.D., M.Ch., F.R.C.S., to be Director, Egyptian Government School of Medicine, 1919.

Capt. Horace E. H. Tracy to be Civil Surgeon, Civil Health Service, Mesopotamia.

Reviews, etc.

An Index of Symptoms with Diagnostic Methods. By Ralph Winnington Leftwich, M.D.; Seventh edition revised by H. N. Warner Collins, B.Sc., M.R.C.S., L.R.C.P.London (Messrs. John Murray, 1920); price 15s. net.

The literature of medicine is full of short cuts to knowledge. Their appeal is chiefly to the student harrassed by the proximity of his final examination; but publishers and authors, anxious to increase the possible field of purchasers, usually include "the busy practitioner" amongst those to whom their "Tabloid" medical works will prove useful. The present volume is an exception to the general rule in that it claims to be the vade mecum of the practitioner rather than that of the student. It is a short cut to diagnosis rather than to knowledge. Personally we are of the opinion that there is no short cut to accurate diagnosis. The ability to make an accurate diagnosis rests upon four factors —wide knowledge, power of accurate observation, the ability to make correct deductions, and, last but not least, upon experience. We cannot admit that the book under consideration is an adequate substitute for any of these four factors, and we should hesitate to make use of, or recommend the services of, any doctor whom we knew to be in the habit of depending on such a work for his diagnoses. Having said so much on general principles, we may add that the volume has many attractive and admirable features. It is a mine of information, and both its author and its reviser must have spent immense pains to make it as complete as it undoubtedly is. The introduction, dealing with the fallacies of diagnosis is well worth reading. But the utility of the book still remains questionable. A formidable array of diseases is classified under every conceivable symptom. The claim of the book is that a practitioner puzzled by a patient complaining of, say, abdominal pain and vomiting can come home and turn up the symptoms in his book. He will then be faced with a list of all the diseases in which a patient could possibly complain of these symptoms and can make a selection. It cannot be denied that such a method might occasionally yield a correct diagnosis, even in obscure cases. Our contention is that the danger of the doctor confidently making a wrong diagnosis would be so great as to outweigh the advantages of an occasional success. Short cuts are notoriously dangerous things especially when the traveller has an imperfect knowledge of the country in which he is travelling. The present volume is, we believe, no exception to this rule.

Handbook of Skin Diseases. By Frederick Garviner, M.D., F.R.C.S.E. (Messrs. E. & S. Livingstone); pp. 160, 46 illustrations.

This is a useful little book. In his desire to produce a small volume the author has very wisely omitted or referred to in a few lines all skin diseases which the general practitioner will only rarely meet. The common diseases of the skin are treated clearly and intelligently with most attention to their clinical appearance and treatment. The teaching of the Edinburgh School has been followed, and so the term eczema had given place to dermatitis. The indications for different lines of treatment are well brought out, and a confusing superabundance of remedies avoided. Withal, the book is well written and interesting, and is far from being the unprofitable cram book which so often results from the effort of trying to be brief. Unfortunately, the illustrations do not always come up to the excellent standard of the rest of the book, and some, for all the information they convey, might as well be omitted. This is one of the best small books on skin diseases that I have yet met.

Child Welfare. J. Sim Wallace, D.Sc., M.D., L.D.S. (Messrs. Ballière, Tindall & Cox); pp. 102, price 5s. net.

The aim of this book is to show the Medical Profession the root cause of dental caries in children. Dr. Wallace attacks the subject in a way that is new to some of us. He contends that the physiology of dietetics and of oral hygiene is wrongly taught by almost all physiologists. Dietetics is not merely a question of calories and vitamines; the giving of a purely sloppy diet to a child of a year, although it may be easily digestible and contain all the necessary ingredients is, in his opinion, only asking for trouble. A child with teeth should be given the opportunity to use them, and meals should be constructed to give the child the chance of doing so from the time it leaves its mother's breast. Again, every meal should be arranged so as to leave the mouth physiologically clean. The usual habit of ending a meal with sticky puddings is condemned and fresh fruit is considered to be the proper ending. Sweets before bed, and food between meals, he strongly protests against. The physiologist teaches that saliva has the functions of lubricating the bolus and of digesting starch. Dr. Wallace holds that these are only of secondary importance. Saliva is primarily intended to protect and clean the mouth. Food properly masticated is swallowed as a semi-fluid; the mucus in the saliva preventing damage to the mucous lining in the mouth and in the stomach. Since the mucus of the saliva is precipitated by acid, it aids the hydrochloric acid to penetrate the food. Ptyalin, we know, digests starch, but Dr. Wallace considers that this function is not to aid digestion but to help to remove carbohydrate debris from the cracks and crevices of the mouth. These and other interesting conclusions are strongly supported by trenchant arguments, and the usefulness of the book is added to by several very practical diets for children. One would like to see some physiologist take up the cudgels in support of *their* teachings. The reviewer was so struck with the arguments of Dr. Wallace that he promptly went out and bought a pound of apples to eat after his suet puddings!

Diseases of Women. By T. G. Stevens, M.D., B.S., F.R.C.S., M.R.C.P. (Messrs. Hodder & Stoughton); 2nd edition, pp. 443. Price 20s. net.

The second edition of this work shows signs of a very complete revision. Nearly all German names have been removed from the text, but what is of greater value, the author's experience during the seven years since the 1st edition has been freely used, and nearly every chapter has some changed opinion, some confirmation or otherwise of a new line of treatment, and this has distinctly added to the value of the book. The treatment of syphilis has been thoroughly brought up to date, and a very convenient scheme outlined.

Notice.

University of Cambridge.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES. EASTER TERM, 1920.

PART II.

PHARMACOLOGY AND GENERAL PATHOLOGY.

Order of Examination.

(subject to alteration in details, of which due notice will be given).

Tuesday, April 27th, Wednesday, April 28th, Thursday, April 29th. 9.30 a.m. and 2.30 p.m. Oral and Practical Examinations in Pharmacology and General Pathology. In the Medical Schools.

The Registrary begs leave to give notice that the names of candidates of the above-mentioned Examination, arranged alphabetically, should be forwarded to him on or before Tuesday, April 6th. Forms on which entries may be made will be sent to the Praelectors of Colleges.

The First List will be issued on Tuesday, April 13th.

Additions and corrections must be sent to the Registrary not later than Saturday, April 17th.

Certificates must be sent in on or before Saturday, April 17th.

The Corrected List will be issued on Tuesday, April 20th.

The Examination begins on Tuesday, April 27th.

Guy's Hospital Cricket Club.

There will be a General Meeting of the above on Monday, March 15th, at 1.30 p.m. in the Physiological Theatre. Mr. C. H. Fagge will preside. Agenda: Minutes of last meeting; election of officers and committee; certain proposals and any other business. All interested in Hospital Cricket should make certain of being present.

G. P. LINDSAY,
Hon. Sec., G.H.C.C.

Football.

RUGBY.

GUY'S v. COVENTRY.

On Saturday, February 23rd, the Hospital XV. journeyed down to Coventry with a full side (excepting for Marais, Reitz and Neser). After a good fast game they returned victors by the handsome margin of 26 points to ten. This victory was due largely to the speed of the backs, who not only ran well but also handled the ball with great accuracy. One well-known sporting paper states that "the smart and clever handling of the Hospital backs was the best seen on the Coventry ground this season."

Coventry started off very strongly. Pemberton managed to evade our defenders and gained a good try ten minutes from the start. This was replied to by Graham Davies, who got a try too far out to be converted. Then Simpson, a Coventry forward, got over, to be imitated before half-time by Daneel, who ran behind the posts. By some strange lapse this was not converted.

The forwards played up splendidly as soon as the game recommenced, and plenty of chances came the way of the backs, who seized on every opportunity. P. Krige went over with three tries and Daneel with one, Van Schalkwijk adding the extra points to all four tries. The whole team played well, and if they can keep this form up to the season's end our record will indeed be a splendid one. Final score: Guy's, 4 goals, 2 tries, 26 points; Coventry, 1 dropped goal, 2 tries, 10 points.

Guy's team:—W. Olivier, A. Daneel, P. J. Krige, J. A. Krige, H. Graham Davies, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, A. H. Shellswell, G. E. Kidman, H. Van Zijl, R. F. H. Duncan, L. K. Watson, C. Pauw, and G. Zondagh.

GUY'S v. ST. THOMAS'S.

THIRD ROUND, UNITED HOSPITALS' CHALLENGE CUP.

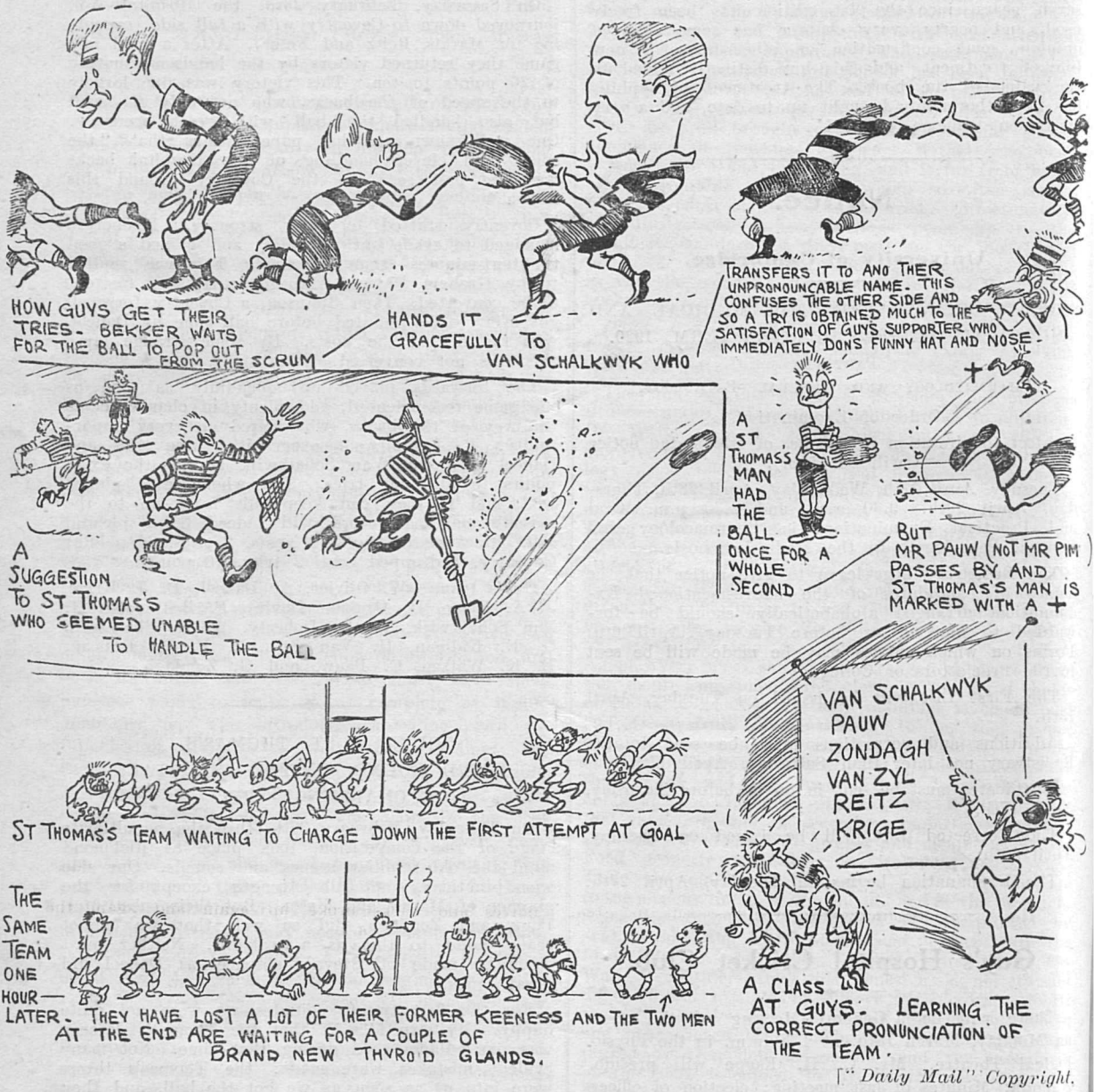
On Thursday, February 26th, this, the penultimate stage of the competition, took place at Richmond amid the old familiar scenes and sounds. Our side was practically at full strength except for the absence of Marais and Neser. But their substitutes, Pauw and Zondagh, did so well that we cannot really point to this as a weakness. Neither must much be made of Steyn's absence, as Daneel did great work.

For the first twenty minutes we were not quite happy. My own idea is that the Thomas's defence was particularly good during that time. Not many evident mistakes were made; the Thomas's threes were into us as soon as we got the ball, and they tackled well. Two attempts at dropping a goal were tried by Van Schalkwijk, and then some good passing sent J. A. Krige away. Tackled, he fell heavily, and had to be carried off, but pluckily soon came back. During his absence and fully 20 minutes from the start, Van Schalkwijk went through

and scored our first try. Then fine passing saw P. J. Krige score, for Davies to land a fine goal. Daneel got a try from another splendid round of passing. Shellswell barged over with yet another.

Playing good hard football, our backs were early on the move as soon as play was resumed. The forwards heeled smartly, and Bekker was really magnificent; he finds out Van Schalkwijk's position

HOSPITALS RUGBY CUP SEMI-FINAL. By TOM WEBSTER.



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Then came a piece of grand work by Graham Davies, who gave P. J. Krige a perfect pass, and the wingman did the rest. We were 17 points up at the interval.

uncannily and with the greatest accuracy sends his partner the ball. Van Schalkwijk at his best got his threes away finely. J. A. Krige scored a try, and Davies scored a beauty just after. Van Schalk-

wijk converted both. Bekker next slipped through on his own; he always does this once in a match. Then came Daneel along with a fine run. Van Zijl broke clear just after, but did not use his pace in going for the line. The last score came from P. J. Krige. Though slightly lame, he stuck to his task well, and one hopes his injury is not severe. This ended the scoring. One is sorry not to say more about Thomas's. Twice their wingmen got away, but Olivier got in a grand tackle, and the other run ended with a fruitless kick. Splendidly J. Churcher tackled at full-back, and though sorely and often tried, he kept his spirit up to the end of a trying game. One other man small of stature but great of heart on Thomas's side tackled till he was almost dead beat. He was splendidly plucky, and I am sorry I cannot remember his name. Score: Guy's, 3 goals, 6 tries, 33 points; Thomas's, nil.

Guy's team:—W. Olivier, P. J. Krige, J. A. Krige, H. G. Davies, A. Daneel, F. Bekker, J. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. H. Shellswell, R. R. F. Duncan, H. Van Zijl, A. Pauw, G. Zondagh, and G. E. Kidman.

Remarks.—The backing up of the man with the ball fell off as soon as points began to accumulate—rather a pity. Olivier did well; the whole back division were good, especially Bekker and Davies. Doherty led his men grandly, and Shellswell, Van Zijl and Kidman were the pick of an excellent pack. If all get absolutely fit by March 11th we can hope with confidence to welcome the Cup home again to the Boro.

GUY'S v. OLD LEYSIANS.

After our match with St. Thomas's on Thursday we had several men away from this match at Wandsworth on Saturday, February 28th. A glance at the team will tell at once that the side was largely made up of reserves; right well they played too. The only grumble I would make is that the forwards did not push hard enough in the scrum during the latter portion of the game. No Guy's pack should allow seven opponents to get the ball as frequently as the Old Boys did after half-time.

Play had scarcely commenced before we had a try scored against us. The ball was punted over by the corner, and Walker reached it before Van Heerden got to it. From now on, our men played splendidly, and Van Schalkwijk went over with a typical try, cleverly dodging through the defence. Reitz kicked well for goal, but he was not quite successful. Brilliantly the three-quarters handled. Davies was splendid, and Williams ran in great form from half way to score as good a try as one could wish. Pauw almost converted this with a fine kick. Then Williams did exactly the same thing again, Davies having first given him a perfect pass. But Williams had the ill-luck to lose the ball when over the line. After this incident Van Schalkwijk scored again. Van Nickert ran down and sent the half-back a lightning inside pass which was beautifully gathered. This time Pauw kicked a good goal. Bekker and Van Schalkwijk have never been together so well, and to the former fell the next try, which went unconverted. It was obtained by one of Bekker's famous dives for the line.

Shellswell, Van Zijl, Pauw and Kidman were the best forwards, but the heeling was bad in the second half, and Shaw was not quite safe in his handling. No score came for a long time, till perfect passing sent Williams in again. Van Schalkwijk had no difficulty in converting. Once or twice the Leysians got away and Van Heardin got in a good tackle or two. But on the whole the tackling was not good. Go low and wholeheartedly, put your man down. Eyebrows and shoulders are not the portions of the human frame to tackle. A neat kick by Van Schalkwijk over the Leysian backs and a very smart follow up by Williams secured our last try, and the game ended: Guy's, 2 goals, 4 tries, 22 points, to 1 try, 2 points.

Guy's team:—H. Van Heardin, J. Van Nickert, T. A. Shaw, H. Graham Davies, H. K. Williams, F. Bekker, J. G. Van Schalkwijk, F. W. Reitz, G. E. Kidman, H. Van Zijl, A. H. Shellswell, A. Pauw, G. Zondagh, L. J. Biddle, and A. Bradley.

ASSOCIATION.

GUY'S v. ST. THOMAS'S.

SEMI-FINAL OF INTER-HOSPITAL CUP.

Playing on the London Hospital ground on Wednesday, February 18th, Guy's won by 3 goals to 1.

The few supporters who turned out in the northern mists were rewarded by a fast and keenly-fought game. Unfortunately, after the first half-hour we lacked our captain, Lindsay, who, while trying to beat the opposing half-back, fell heavily and broke his leg. We wish him a speedy recovery, and fear it will be hard to fill so efficiently for the final tie the gap he leaves in the side.

From the beginning of the game Guy's attacked, Coxon being robbed of a good chance from a centre by Lindsay, owing to the inopportune "kick" of the ball as he shot; however, our forwards were soon back again, and following a scramble in front of goal, Trott scored our first point after about ten minutes.

The small but enthusiastic contingent of Guy's men cheered lustily, but almost straight from the kick-off the Thomas's right wing went down the field. Hore failed to gather the centre, and the ball was bundled through while he was on the ground.

Again the game swayed from end to end, but our backs were steady, and we were soon ahead again, Coxon availing himself of a chance after Rayner had lobbed the ball into the goal-mouth.

After losing Lindsay the result seemed a very open question. However, the Thomas's defence were never left at peace by our forwards, and our own halves and backs broke up again and again the many Thomas's attacks.

About fifteen minutes from time our position was made safe by another goal from Trott, the Thomas's goalkeeper failing to clear completely a centre from the right wing.

It is hard to single out particular players when all worked so hard and well—probably, once again, our great strength was in the half-back line.

If Rayner would draw the opposing half, he would be able to part with the ball to greater advantage, and the side would get the full benefit of the boundless energy he displays.

The backs and goalkeeper stood the pressure well, while for more than half the game the four remaining forwards did the work of five, and did it

quite well, a testimony to their fitness. The last goal was the result of Van Geun's ability to put in an extra sprint at the end of a really strenuous game.

Guy's team:—W. Hore, C. A. Wakeford, A. Riddolls, F. Rayner, D. J. O'Meara, Couch, R. Van Geuns, Trott, A. C. M. Coxon, Pengelly, and G. P. Lindsay (Captain).

Golf.

Under very pleasant weather and ground conditions, the Hospital Staff played the Students at Sundridge Park Golf Club on Wednesday, February 18th. The result was a win for the Students by four matches to two after a most enjoyable afternoon.

There were some very good scores put in, the best being by O. G. Morgan for the Students 79. Bogey 78, Dr. Cameron 82, Dr. Hunt 84, G. M. Stuart 89, Mr. Davies-Colley 89. The following cards are of interest:—

Holes	Yds.	Bogey.	O. G. Morgan.	Dr. Cameron.	Dr. Hunt.	G. M. Stuart.	Mr. Davies-Colley.
1	468	5	5	5	5	7	7
2	323	4	4	5	5	5	5
3	300	4	3	4	4	4	6
4	178	3	3	3	4	4	3
5	454	5	4	5	5	6	4
6	311	4	6	3	4	5	5
7	361	4	3	3	3	3	3
8	446	5	6	5	6	7	6
9	414	5	4	5	5	5	5
10	513	6	6	6	8	5	6
11	353	4	4	5	5	5	5
12	200	4	4	4	3	5	5
13	325	4	5	5	5	5	6
14	364	5	5	5	5	5	6
15	442	5	6	7	5	5	5
16	314	4	4	5	4	5	5
17	128	3	3	3	4	3	3
18	278	4	4	4	4	5	4
		78	79	82	84	89	89

The result of the match is as follows:—

STAFF.

Dr. Cameron	0
Dr. Hunt, 4 and 3	1¼
Mr. Davies-Colley, 2 up	1
Mr. Mollison	0
Dr. Ryffel	¼
Mr. Hughes	0
	2½

STUDENTS.

O. G. Morgan, 4 and 3	1¼
G. M. Stuart	0
K. F. McAlpine	0
J. W. Stiven, 2 up	1
A. A. Crowe, 7 and 6	1
H. A. Coysh, 8 and 7	1¼
	4½

Golfers! Remember there is a medal to be won every month, and everyone even with a high handicap has a chance. Also, up till now, although regular members have been turning out, we want more recruits. There is a Hospital Cup to be played for in the near future. It is at present held by St. Thomas's Hospital.

It would be possible to run a Junior Hospital Golf Cup if more members would turn out at the Monthly Medal round, and matches would be arranged.

Pass List.

Society of Apothecaries of London.

Feb., 1920.

Surgery.—W. H. Cellier (Section 1).

Medicine.—*G. R. Aspinwall, C. C. Bennett, W. H. Cellier, J. Kendall (Section 2).

Forensic Medicine.—*G. R. Aspinwall.

Midwifery.—*G. R. Aspinwall.

*Has now completed the examination.

Honours.

ORDER OF THE BRITISH EMPIRE.

W. F. R. Burgess, M.D.

Specialities.

MESSRS. BRAND & CO., MAYFAIR, LONDON, W.

As a standard preparation for Invalid Dietary, especially in cases of extreme exhaustion, Brand's Essences of Beef, Mutton and Chicken have received the unanimous approval of the Medical and Nursing Professions. These essences consist solely of the juice of the finest meat, extracted by a little heating, without the addition of water or any other substance whatsoever; they contain, therefore, the most stimulating and exhilarating properties of the meat in the most easily assimilated form. In cases of weakness, lassitude, malnutrition, at such critical periods as follow severe operations, or in the case of women, at child-birth, Brand's Essences provide an easily digestible form of nourishment which speedily build up health and strength.

In spite of the very high prices of meat, Brand's Essences still maintain their unvarying standard of quality. These nourishing preparations are sold by all high-class Chemists, Grocers and Stores.

Births.

ROWSE BASTARD.—At The Cottage, St. Tudy, Cornwall, on February 20th, the wife of H. Rowse Bastard, M.R.C.S., L.R.C.P., of a daughter.

MULLALLY.—On Friday, February 27th, at 4, St. Thomas's Street, to Mollie, wife of G. T. Mullally, a son.

TRACY.—On January 9th, at the Nursing Home, Henley Road, Ipswich, the wife to Capt. Horace E. H. Tracy, Civil Health Service, Mesopotamia, a son (David Quinn).

Death.

REEVES.—On February 14th, at 6, Streatham Hill, S.W., Mercy Earey, only child of Capt. Albert Reeves, R.A.M.C., suddenly from heart failure.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE hope expressed (and the result anticipated) in the last issue of the GAZETTE has materialised; the Rugby and Association Football Cups have returned to Guy's. We offer our congratulations to the teams and to their Captains, Mr. W. D. Doherty, Mr. G. P. Lindsay, and Mr. Coxon (Coxon, it will be remembered, stepped into the breach and took charge of the Soccer team after Lindsay's unfortunate accident the other day). Everybody concerned worked hard and achieved a well-deserved success.

We publish several pictures of the match in this number of the GAZETTE, and hope in the near future to print a photograph of the winning teams.

A word of praise is due to the Bart.'s team, who played extraordinarily well; the result remained in doubt almost until the very end, when Van Zijl scored the second try of the match. Indeed, from the spectators' point of view, the situation throughout the game was far too tense to be really enjoyable.

The presence of the King at Richmond was a feather in the cap of the London Hospitals. Everybody was delighted to see him once again in the Royal Box, where, as Prince of Wales, he had on previous occasions been good enough to witness the struggle which, year by year, decides the destiny of the Rugby Cup.

Reviewing the day of the Cup-Tie as a whole, one of the outstanding features was the success of the Guy's rag. Many an old Guy's man was heard to comment on the striking costumes and excellent organisation of our crowd, and this was due almost entirely to the untiring efforts and originality of Messrs. Edney and Rowbotham.

It was a pity, therefore, that the Bart.'s men were so unresponsive. In the first place, only a comparatively small number of them turned up, and it was fortunate for them that their strength was eked out by a number of students from the Royal Free Hospital.

In the second place, one would have thought that these heroes of the University College and Asquith rags would at least have made one attempt on the Guy's Milk Churn. Whether this seemly reticence was the outcome of a desire to spare the feelings of their lady friends from Grays Inn Road or whether it was the result of an edict from the Bartholomew's authorities requesting their men not to appear in fancy dress and forbidding them to indulge in a rag, we do not know. If the *latter* is the case, all we

can say is that no compliment was paid thereby to His Majesty. The King's sporting proclivities are well known, and we are sure that *he* would be the last person in the world to resent a little harmless scrapping between two rival Hospitals.

In response to many enquiries, we should like to announce that the Teddy Bear captured by the pupils of one of the London Polytechnics was *not* a native of St. Thomas's Street.

One is at a loss to understand the position taken up by the Women of the Royal Free Hospital on Thursday last. Of course, they were quite at liberty to turn up to the match on that date; they were quite at liberty to display a banner with that strange device, "Cheerio Bart.'s," if they wished to. We are merely wondering what is the reason for this display of partizan spirit.

We have just received notices of the deaths of two old Guy's students, Dr. Elford Dupigny, of 45, Streatham High Road, S.W., and Col. J. Duke.

Dr. Dupigny qualified L.D.S.(England) in 1896, and M.R.C.S., L.R.C.P. two years later. Fifteen months ago he broke down in health through overwork. Subsequently, he became paralysed, and this led up to his death on the 28th February last.

Colonel J. Duke was one of eight brothers —all Guy's men. He joined the Indian Medical Service in 1872, and held numerous appointments in India. He served with Lord Roberts through the Cabul campaign (1879-80), and was mentioned in despatches for conspicuous bravery on the field. Later, he accompanied Lord Roberts as personal medical officer on his famous march to Kandahar. During the present war Col. Duke served in several military hospitals in England, until forced to retire owing to ill-health. He died on February 13th.

All those who remember these two gallant men will grieve to hear of their deaths, and wlil unite with us in offering their sympathy to the bereaved.

It was with great regret that we heard of the departure from Guy's of Miss Brabson, late Sister Cornelius, and Miss Illingworth, late Sister Luke. They will be greatly missed by the large circle of Guy's nurses and men who came in contact with them during their work at the Hospital.

Miss Marsh succeeds to Cornelius Ward, Miss Wilson to Luke, Miss Dearman becomes third night sister, and Miss Doubleday becomes third home sister.

We wish all the oncoming sisters the best of luck in their new appointments.

On another page of the Gazette we publish an appeal for funds on behalf of a Memorial to Officers and Men of the R.A.M.C. fallen in the war. This, of course, does not enter into competition with other memorial schemes in any way. It is one of the many deserving appeals that have been sent to us, and we direct the attention of our readers to the notice referred to, which proposes to erect suitable monuments in London, Edinburgh and Dublin, and to devote any surplus funds to grants of aid to families of fallen members of the R.A.M.C.

At the present time the condition of many of the London Hospitals is critical, and the words Nationalization and State Aid are heard on all sides.

The waiting lists for surgical beds is, as we know, enormous; economically, thousands

of men are kept in a C3 category for months when an operation would enable them to do the work of A1 citizens in a few days.

Cases even of great urgency are unavoidably kept waiting for radical treatment, with the result that of them, a definite proportion either die, or become inoperable and beyond help, before admission to hospital.

Again, it is admitted that one of the crying needs of this country are lying-in hospitals for the care of expectant mothers.

On the one hand, therefore, it is necessary to build new hospitals and to extend the old ones, while on the other there exists the terrible shortage of funds which is making it so difficult for existing institutions to carry on their work.

In default of the requisite public donations, it becomes necessary for the hospitals to look for support elsewhere. We commend the following suggestions to the consideration of our readers:—

(a) Re-organisation of infirmaries on the lines of ordinary civil hospitals, with object of removing the existing stigma under which the public associate these institutions with the workhouse and parish relief.

(b) Establishment of *new* institutions, State built and State controlled.

With regard to the existing general hospitals, however, the position is different. These have carried on unaided so long and have so many traditions that it would be a pity to place them under State jurisdiction.

Perhaps the best solution to the problem is the appointment of a representative from the Ministry of Health to the Board of Governors, and the institution of Government grants-in-aid proportionate to the amount of work done by the hospital in question.

This form of State-aid, as pointed out in this week's *Lancet*, need no more place a hospital under the thumb of the State than it places the various colleges and schools of this country in receipt of Government aid under the absolute control of the Board of Education.

Since the publication of the last number of the Gazette we have had very considerable evidence that our appeal to old Guy's men to take an active part in ensuring Mr. F. J. Steward's successful election to the Council of the Royal College of Surgeons has not fallen on deaf ears. The letter which we publish elsewhere reflects the feeling of the majority of Guy's men that at the present juncture it is essential for our School to be fully represented on the Council. We have no doubt as to Mr. Steward's success, but at the same time it is of the greatest importance that no effort should be spared to make that success a certainty. We would reiterate that the way in which the desired result can be certainly achieved is for *every* Guy's man to make a point of approaching those of his friends or neighbours who are Fellows and securing the promise of a vote for the Guy's candidate. The voting papers will be sent out to Fellows on March 27th, and it is of great importance that promises of support should be obtained before that date. We would repeat that Fellows may secure additional votes with advantage from outside sources by giving one of their votes to Mr. Steward and using the others on the basis of an exchange.

Appointments.

Hy. Arthur Latimer, M.D., M.R.C.S., has been elected Mayor of Tunbridge Wells.

William Norman May, M.D., B.S., to be Assistant Physician, Royal Berks Hospital.

C. Jephcott, M.A., M.B., M.C., to be Hon. Anæsthetist, Royal Infirmary, Chester.

H. S. Wacher (1) to be Medical Officer-in-Charge, Venereal Clinic, Canterbury; (2) Medical Officer to the Post Office, Canterbury.

Hildred B. Carlill, M.A., M.D., B.C., M.R.C.P., to be Physician to the Westminster Hospital.

"Shall I send for the Take-in H.S. ?"

OR

Ears in the Front Surgery.

CLINICAL LECTURE BY T. B. LAYTON, M.S.

GENTLEMEN,—Let us imagine, for a short time, that each of us is a dresser in the front surgery and that we belong to that type of dresser who, though he loyally supports the Out-Patient Officer by showing him every single case before he deals with it, yet tries to learn by making up his mind what he would do with the case if he were the Out-Patient Officer who had to decide. If we do that we shall learn in the "front" more clinical medicine and surgery than we shall in double the time spent in listening to the converse of our seniors. We shall also develop that power of judgment and of responsibility which will carry us through life outside these walls, to an extent far greater than will any amount of book-lore. And I would have you remember this: that your experience in the surgery is the nearest approach which hospital life affords to that which you will have in the world outside whatever branch of medicine or surgery you take up. Your decision as to whether you will send for the Out-Patient Officer is based on the same problems as will face you when, as a general practitioner, you find yourself at midnight in a farm on the Yorkshire Wolds and have to decide whether to get on the telephone and have out a surgeon from Hull or from York or when, as a surgeon on an Atlantic liner, you have to decide whether to tackle the case yourself with the steward giving the anæsthetic on the chart room table.

TABLE II.

Pain in the Ear.

a. *Lesions of Middle Ear and its Extensions—*
   - Acute Otitis Media, with mastoiditis involving the mucous membrane.
   - Acute Otitis Media, with mastoiditis with an osteitis of the mastoid bone.

b. *Lesions of the External Auditory Meatus—*
   - Furunculosis.
   - Myringitis.
   - Dermatitis.
   - Burns.

c. *Dental conditions—*
   - Carious molar.
   - Impacted wisdom.

d. *Inflammation of Lymph Glands—*
   - Retro-auricular.
   - Pre-auricular.
   - Between mastoid process and angle of jaw.
   - Deep, below muscles.

e. *Lesions of Temporo-mandibular Joint—*
   - Results of injuries.
   - Osteo-arthritis.
   - Gonorrhœal arthritis.

f. *Lesions of the Parotid—*
   - Mumps.
   - Abscess.

g. *Lesions of Skin and underlying Tissues—*
   - Burns.
   - Erysipelas.
   - Cellulitis.
   - Muscular lesions.

TABLE I.

Pain.
Discharge.

Tenderness.

Œdema.

On Table I I have put four symptoms on which I wish to lay stress. Pain and discharge because they are the two for which ear cases most often attend. Tenderness because of its extreme importance in diagnosis. Œdema for its importance in prognosis.

TABLE III. *Tenderness.*	TABLE IV. *Œdema.*
Mastoiditis.	
Osteitis of mastoid bone.	Osteitis of mastoid.
Furunculosis of meatus.	Furunculosis.
Inflamed lymph glands.	
Joint lesions.	
Parotid gland lesions.	
Burns.	Burns.
Erysipelas.	Erysipelas.
Cellulitis.	Cellulitis.
Muscular lesions.	

Table 2 gives a list of lesions which cause pain. "Pain in the ear" is the patient's term. He does not differentiate between pain actually in the ear and pain in front or just behind it. In Table 3 I have put a list in which examination shows that the pinna or part near is tender. Table 4 gives a similar list for œdema.

I propose first to pass through these rapidly, and then to lay particular stress on certain important points.

The first group includes the ear cases *par excellence*; lesions of the middle ear and its extensions. By acute otitis media I mean an inflammation of the mucous membrane lining the tympanum, which has spread from the naso-pharynx. We will not consider perforating wounds or ruptures of the drum-head. By acute otitis media with mastoiditis involving the mucous membrane, I mean the inflammation has spread over from the middle ear into the mastoid, and is also involving these pneumatic cells and the mucous membrane lining them. Although at this stage there may be some exudation into the bone immediately surrounding those cells, there is not yet actual pus formation or inflammation of the bone itself. It is at the stage of osteitis of the mastoid bone that you have that to which we casually refer as an "acute mastoid." This is a lesion which requires immediate operation, and it has got to be differentiated from these various other conditions, any of which will bring the patient to the hospital on account of pain in the ear.

Now we come to lesions of the external auditory meatus. I have put up furunculosis in the first place because it is the commonest of the lesions of the external auditory meatus and because it is the most difficult one to diagnose from these other lesions, particularly from osteitis of the mastoid. Most of my time at this lecture will be devoted to trying to help you to tell the difference between furunculosis of the external meatus and osteitis of the mastoid bone.

By myringitis I mean an inflammation of the outer layer of the drum of the ear, starting from the outside, not secondary to the inside. It is mentioned in books on the ear, but it must be very rare, and I advise you not to lay too much stress on it, because probably there is some inflammation deep to the drum, and therefore it is acute otitis media after all.

By dermatitis I mean an inflammation of the external auditory meatus, other than inflammation the sebaceous glands of the ear. Many of the forms of dermatitis are due to trauma, either because the patient has picked the ear with the head of a pin or a match-stalk, or from some drops which have been put into it. Drops which are put by patients into their ears may cause trauma, not because they are strong drops but because they are applied too hot. For that reason I have put down burns of the external auditory meatus as one of the causes of ear pain.

Next I give a list of conditions easily excluded, but for which you must keep your eyes open. Dental causes include carious lower molars, which will cause a referred pain in the ear, and the closely related condition of an impacted wisdom tooth. I shall not now enter into detail about inflammation of lymph glands; I hope to return to that later.

Next we have conditions you must remember, but which are not very common, nor difficult to diagnose. I had a man sent to me at the Aural Board recently because he complained of ear-ache. There was nothing wrong with his ear at all, but he had had a wound injury which had involved the temporo-mandibular joint, and that caused pain whenever he moved his jaw. The pain was in front, rather low down, and was easily excluded.

In lesions of the parotid gland again the swelling is in front of the jaw. We had a student in the Out-Patient Department two weeks ago who complained of ear ache. His ear was quite normal, but he had some swelling in front of the left ear. I thought it might be mumps, until a clinical assistant told me you must not diagnose mumps unless the swelling is bilateral. A few days later he was much worse with a large fluctuating swelling in front of the ear, and we got him into Astley Cooper ward, under Mr. Rowlands, who opened a large parotid abscess. This is a rare condition, but, remember, he originally came to us for ear-ache and nothing else.

Then I give you a series of conditions which are more important from the diagnostic point of view: lesions of the skin and underlying tissues. Erysipelas is not unfrequent, and it is hard to decide whether there is an acute osteitis of the mastoid underneath. Another

thing, on which I want to say more later, is the question of burns. The patient may have had pain for some time, and he may have applied heat to the area, and in that way he may have actually caused some burn over the mastoid. It is important because it makes so much more difficult the decision as to whether you should or should not operate. We have had two such cases since last October. Cellulitis is a further extension of erysipelas. I have put down also muscular lesions, because I think pain in the muscles is sometimes referred to the ear.

When you go to the next list, you see you have excluded a number of conditions by examination of the tenderness. Acute otitis media, by itself, is intensely painful, but it is not tender. It is not until there is inflammation in the mastoid that you begin to find tenderness behind the ear. I want you to distinguish between mastoiditis and osteitis of the mastoid process, because I am sure patients are tender behind the ear with mastoiditis limited to the mucous membrane, which is recoverable by puncturing the drum, and by simple general treatment without operation. It is when there is acute osteitis of the mastoid bone that operation is needed. Furunculosis I shall discuss when we come to consider sites of tenderness. Lymph glands are tender. Lesions of the temporo-mandibular joint and parotid are tender. There the tenderness is in front of the ear, and therefore I shall not discuss it. It is when the tenderness is behind the ear that differentiation is difficult. With regard to the skin and underlying tissues, if you burn the area behind the ear, it is very tender.

Table V.

a. *Cases with which one can deal as an Out-patient*—
   Acute otitis media.
   Lesions of external ear.

b. *Cases which should be admitted for observation*—
   Acute mastoiditis.
   Cases of doubt in diagnosis between furuncles and osteitis of mastoid.
   Burns behind pinna.

c. *Cases which need to be admitted for operation*—
   Acute otitis media with osteitis of mastoid process.

In Table 5 I have put up a clinical list of the sort of cases which come to the front surgery. Firstly, there are the cases you can deal with as an out-patient. I do not necessarily mean you can send these from the front surgery to the surgeon next day, you may have to deal with them in the surgery yourself. If you decide that it is nothing but acute otitis media, then please puncture the drum in the surgery and let the patient come to the throat surgeon the next day or, if it is a Saturday night, as soon as he can. If you convince yourself a patient has furunculosis and nothing more, although the patient may look very ill, deal with him as an out-patient. Open the furuncle in the surgery, if you can see exactly where it is. If you cannot do that and yet are confident it is only furunculosis you need not be anxious about it.

Next are cases which should be admitted for observation. I would impress upon you the fact that the surgical beds in this hospital are meant not merely for cases that will have operations performed but are also meant for cases to come in for surgical treatment by any method. These include acute cases which may need operation within the next 24 hours, but which may, on the other hand, get well without. Acute mastoiditis involving the mucous membrane is a condition which will frequently get well by puncturing the drum and by general treatment but, if it is left, it is very liable to go on to the next stage, which is osteitis of the mastoid process and to need operation very soon. By taking the patient into hospital, you have two advantages. First you have a much better chance of cutting the condition short and preventing it becoming osteitis of the mastoid bone. Secondly if it does proceed to osteitis you will know about it much sooner and operation can be done sooner than if he had to come up to the out-patient department. In addition the case will yield you far more clinical instruction. Diagnosis is pretty clear in 24 to 48 hours and if it is not osteitis the patient can go out.

The next kind of case which should be admitted for observation is where there is some doubt whether it is furunculosis or osteitis of the mastoid. This class will probably include by far the majority of the cases with which you will have to deal. No week passes without our having in the Ear Department to decide between furunculosis of the external auditory meatus and osteitis of the mastoid process.

I have put down burns behind the pinna, because if you have a person who may have an acute mastoid but has been burning himself by applying heat behind the ear with ex-

cessive vigour the difficulty of deciding from a single observation is so great that I strongly urge you to take the patient in and keep an eye on him. We have had two such cases in the last four or five months. One we had in on Thursday. We looked at her on Friday morning, and on Friday afternoon we thought it was not a mastoid. I was anxious about the child, and went to see it at 7.15 on Saturday morning, and operated at 8 o'clock. The other case was one in which Mr. Scott, the clinical assistant, thought it was an acute mastoid. We hung on to him for about a week and it proved not to be acute mastoid. The difficult thing with a patient who has burned himself behind the ear is to decide whether the œdema is due to the burning or to osteitis of the mastoid.

Now we come to the cases which must be admitted for operation, namely, acute osteitis of the mastoid bone. These come under three heads. Cases in which there is œdema behind the ear, cases in which there is a boggy abscess behind the ear, and cases in which there is tenderness there without œdema or obvious abscess formation. About the cases of abscess it is not difficult to decide. They only have to be diagnosed from abscess of the retro-auricular gland. This latter is not likely to cause much displacement of the ear and by careful palpation you can feel that the abscess is superficial. They are not cases about which you need be very anxious; they always do well. The cases that cause me anxiety are those of osteitis of the mastoid bone in which there is œdema. My experience is that if there is œdema behind the ear and there is mastoiditis, you are more likely to have an extra-dural abscess than you are if there is no œdema. It looks as if the disease, not having spread externally, has tried to extend internally all the more.

But remember that osteitis of the mastoid bone is not the only cause of œdema of the mastoid process. Furunculosis of the external auditory meatus may also cause it. Possibly a year ago I should have told you not to believe that furunculosis of the external auditory meatus caused œdema of the mastoid bone, but since then I have seen an appreciable number of cases which have got quite well without operation, and they have been due simply to furunculosis. But I do believe that if you have a middle ear lesion with œdema over the mastoid process it is your duty not to go to bed that night until you have operated upon the patient.

TABLE VI.

Diagnostic Points.

Care of examination.
A period of observation.
Site of the tenderness.
Condition of external auditory meatus.
Condition of drum-head.
Condition of the patient.
Presence of enlarged lymph glands.
Hearing.
Displacement of pinna.
A single observation of temperature.
Clinical chart.
Presence of other conditions to account for an acute illness.

My next list concerns diagnostic points. I have already been over some of them. I draw your special attention to the need of care in the examination of the patient. My experience is that far more mistakes are made through carelessness than through ignorance. Care in the examination is the thing which will carry you through and sometimes a very small point will be the deciding one. When mistakes are made it will be because you are over-tired or that you are in a hurry, or because you would not put forward the mental effort to get the patient into the proper little examination room. If you are in a hurry, it is your own fault. If you do not get the patient into the proper examination room, it is your own fault. If you are over-tired you may be forgiven, but that is the least of the causes of mistakes being made.

After care in the examination, I put down, as the most important point, the period of observation. Either take the patient into the hospital, or see him again tomorrow morning. Now that we see throat cases at out-patients on Monday, Tuesday, Thursday and Friday, there are no long intervals between the days. And always if you are in doubt after a careful examination take the patient in and let him be thoroughly examined there.

TABLE VII.

Site of Tenderness.

1. Pinna.
2. Over the mastoid antrum.
3. Over the mastoid bone.
4. Over the mastoid bone and sterno-mastoid.
5. Over the gland between the mastoid and the jaw
6. Diffuse tenderness over the occipital bone.
7. Diffuse tenderness over the occipital bone where covered by muscle.

The next most important point is, I think, the site of the tenderness. Do not tap the head and ask if it hurts. Put your hand on his head, and do not ask him anything. Then go over these various points systematically, and notice if he winces. If he winces on account of osteitis of mastoid he will draw his head back and there is no need to look at him. Next, when examining the difference between 1 and 2 and 3 on Table VII. you must press either on the pinna or on the mastoid, not on both. When you are pressing for furunculosis, you must press on the pinna; when you are examining for mastoiditis or osteitis you must press inwards and not move the pinna, for the movement of the pinna will make you think he winces as the result of osteitis, when he has only got furunculosis. With regard to tenderness of the pinna, there is one rare form of mastoiditis which may cause inflammation of the pinna. I have never seen it, but I have always got it in mind as a possible cause. It is the condition in which the abscess leaves the mastoid process and bursts, not externally, nor into the brain, but deep down into the external auditory meatus. This gives you the clinical symptoms of furunculosis. If you make a mistake about such a rare condition it is pardonable.

I make a distinction between 2 and 3 there, because by No. 2 I mean tenderness over the mastoid antrum, and by No. 3 tenderness over the mastoid bone below the antrum. I do that so as to distinguish between mastoiditis involving the mucous membrane, and osteitis of the mastoid process. You may have a patient who is not very ill, and who has no swelling behind the ear. You know there is otitis media, and you are wondering whether it is stepping over that stage and going on to acute osteitis of the mastoid. If the pain is limited to the mastoid antrum call it mastoiditis, take it in and treat it for 24 hours, and the odds are that it will get well. If not you will have plenty of time in which to operate upon it. If the tenderness is lower down, and the patient is looking very ill, and the general symptoms are very marked, even though there be no swelling behind the ear, you must call it acute osteitis of the mastoid bone, and you must operate. No. 3 is really the same as No. 6 only 6 is further away. When there is tenderness a long way back and it is due to mastoiditis it is a serious symptom and you must not hesitate in such a case because it means there is a diffuse involvement of the osseous tissue. If there is such involvement in one direction the odds are that it is diffuse in another direction too. If it is not near the meninges or the lateral sinus there is at least a large amount of osseous tissue involved and the patient is more seriously ill.

I now want to compare 3 and 6 with 4 and 7. The latter are places where there is not only bone but also muscular attachments under the examining finger. That brings in the muscular lesions I have mentioned. I think these are really inflammations of the deep glands in the neck, beneath the muscles. I think it is more or less a habit for students to examine for mastoid tenderness by pressing under the mastoid in an upward direction. I do not think it is a good plan because when you do so you are not only pressing on the bone but also on the sterno-mastoid and through this upon the glands which are deeply seated. We have had two cases recently. One was taken in under Mr. Rowlands by Mr. Lloyd—a little girl who had torticollis. I saw her in a corner of the ward just before dinner, jumped to the conclusion that it was a mastoid case and made arrangements to operate on her at 8.15, after dinner. Before he began to give the anæsthetic I started to demonstrate one or two of these points to Mr. Lindsay to show that when there is diffuse tenderness you must do an operation at once and not wait over night. But in this case I then found diffuse tenderness only where the muscles are attached. Then we began to re-consider the matter and after a long examination we sent the child back to bed. We saw her for the next three or four days and she went out without having an operation at all (see Note I). The other case was that in which the mastoid was opened and found healthy. The boy had some swelling behind the ear and was tender right away up. It seemed to be a clear case of acute mastoid so we took the patient in and Mr. Scott operated. He opened the mastoid and found it quite healthy. We never cleared up the actual diagnosis in that case. I have mentioned the gland between the mastoid and the angle of the jaw; that is fairly frequently enlarged and tender.

With regard to lymph glands, I do not believe that otitis media or mastoiditis, or osteitis of the mastoid bone by themselves will cause enlarged lymph glands—retro-auricular, sub-auricular, or pre-auricular.

Therefore if you have a doubtful case and there is no discharge from the ear and the glands are involved it is against rather than in favour of it being a mastoiditis.

You cannot too carefully examine for the site of tenderness in every case that you see, for I am sure it is the most important single point both for diagnosis and prognosis.

Now with regard to the condition of the external auditory meatus and the condition of the drum-head. I shall not say much about those, because I am trying to think of the case as we see it in the front surgery, where the opportunities of looking at the auditory meatus or the drum-head are not great. The Out-Patient Officer has probably got to decide when to send for the House-Surgeon and the House-Surgeon has to decide whether to take the case in without this examination. This must be made later to decide whether operation is necessary. I should be very chary about opening a mastoid in which I was convinced the drum-head was normal. There are many drum-heads in regard to which I may be prepared to hedge, and as to which I am not certain whether they are normal or whether there is something the matter. If there is a bulged drum-head it is almost clearly a case of inflammation inside. If there is a normal drum-head it will in future take a lot of persuasion to lead me to open the mastoid.

With regard to the condition of the patient, that is a thing you pick up by experience and where your front surgery training is so valuable. In some cases you must admit the patient to the hospital because he looks seedy. I shall never forget a case in 1910 in Mr. Steward's Throat Department. He took in a girl who complained of a difficulty in swallowing simply because she looked ill. Within an hour of admission to hospital that patient was dead from a retro-œsophageal abscess extending from the cricoid down to the diaphragm. So also with these ear cases, if the patient looks thoroughly ill take him in. It is much more likely to be osteitis of the mastoid if the patient is very ill than if he is not. By the time you have had the patient under observation for 24 hours, the clinical chart becomes more valuable to you than one single observation can be. If the pulse is quick in relation to the temperature, it looks like an acute septicæmic condition, i.e., acute bone disease. Acute osteitis of the mastoid, so far as general symptoms are concerned, is the same as acute bone disease in the upper end of the tibia or the lower end of the femur.

In considering these cases you will notice I have not laid stress on the hearing. You do not get much chance of examining that in the surgery and you may have to make your decision without it. Moreover, furunculosis of the outer ear may cause severe temporary deafness, because of the swelling of the meatus. I think the hearing test is a much more important guide as to what operation you must do, or how far you are likely to have to go, than in deciding that you must do an operation (see Note II.).

Displacement of the pinna is an important sign. In Hunter Todd's book you will see a picture in which the pinna is not only turned forwards, but is also pulled downwards, and it is stated that such a thing is diagnostic of acute mastoid, as distinct from furunculosis. This type of displacement is usually due to osteitis of the mastoid, and a year ago I should have definitely made my incision through the skin on that symptom only. Within the last six months we have had two cases in which we carefully observed the fact that the pinna was pushed forwards and pulled downwards and the cases were furunculosis, so it is not an absolute sign though it is an important one.

There is, lastly, the question of the presence of some other condition to account for the symptom. We recently had in a little girl who had a running ear with some mastoid symptoms. I did not think the mastoid condition was sufficient to account for it, and I got Dr. Hunt to see her but he could not account for the symptoms other than by the ear. Mr. Mackay opened the ear. She had a site of suppuration. The temperature came down, but rose again in 24 hours. On again opening there was no sign of extension of the disease. She has now signs of bronchiectasis probably as a result of enlarged tuberculous glands in the mediastinum. Children may come with suppurating ears, with a raised temperature, even with sore throat, and yet the trouble may not be due to the ear. If you have a case in which you are not sure, go carefully over the patient with the object of excluding anything else.

TABLE VIII.

Acute Enlargement of Lymph Glands.

Furunculosis of external auditory meatus.
Dermatitis of external auditory meatus.
Acute tonsillitis or pharyngitis.
Carious teeth.
Pediculi capitis.
Impetigo of scalp.
Lymphangitis of scalp.
Thrombosis of veins of scalp.

The next table concerns acute enlargement of lymphatic glands near the pinna. The commonest is furunculosis of the external auditory meatus. Acute tonsillitis or pharyngitis will cause enlarged glands right up to and underneath the ear. But there is a fallacy here because when you get acute tonsillitis or pharyngitis the inflammation may have spread up into the ear and thence into the mastoid. If you work out the tender areas carefully you may find both the pain and the tenderness can be explained by acute tonsillitis and an enlarged gland, but it is a condition in which an enlarged gland may be associated with osteitis of the mastoid and so be an apparent exception to what I have said on the point. Pediculi capitis are one of the commonest causes of enlargement of glands especially right over the mastoid, giving tenderness.

The next commonest condition is impetigo of the scalp. And I have written down two complications: lymphangitis of the scalp, and thrombosis of the veins of the scalp. We have recently had a case in which the tenderness was diffuse and we took precautions to be ready for an extensive operation by shaving off plenty of hair. When we got the hair away we found lymphangitis or phlebitis of the scalp and we concluded there was no mastoid trouble. It seemed as if the child had pneumonia and Dr. Hunt saw her. She had pericarditis, and died from that in the Throat ward having been taken in as a case of acute mastoid.

So you will agree that the cases we have had in the surgery during the past six months have covered a wide range of conditions, and have included a number of cases in which we have refrained from operating. In three cases we have deferred operation and have ultimately had to do one, but the patients have come to no harm because we have had them in the ward under our eyes. In one case in spite of all our care we have opened a normal mastoid antrum.

NOTE I.—Subsequent events suggest that the tenderness in this case was due to a muscular lesion and not to inflammation of glands. The child is now in Esther under Dr. Fawcett with a swelling and tenderness of the muscles of the left forearm.

NOTE II.—This statement needs modification. I should be very chary of opening the mastoid in an acute case in which I was convinced that the hearing was normal.

Pass List.

Royal College of Surgeons of England.

FINAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY, February, 1920.

Part I.

Bremner, S.	Neame, C. S.
Croucher, H. V.	Price, H. K.
Hursthouse, W. R.	Stiven, F. W.
Ide, H. L.	Willis, W. H.
Lean, J. L.	

Part II.

Aldred, A. B.	Fox, F. L. H.
Bryant, E. H.	Gibson, G. P.
Cade, C. R.	Grieve, A. H.
Crowe, A. A. R.	McAlpine, K. F.
Easton, W. A.	White, S. V.

Papers by Guy's Men.

Tom Bird, M.A., M.R.C.S.: Intensive Iodine Treatment, *Lancet*, March 6th, 1920.

Edmund C. Burns, M.A., M.B., B.Ch., F.R.C.S., Eng. and Edin.: Torsion of the Appendix, *Lancet*, March 13th, 1920.

F. N. Doubleday, L.R.C.P., M.R.C.S., L.D.S.Eng.: The Anatomy of Local Anæsthesia, *Brit. Dent. Jour.*, March 1st, 1920.

E. Huntley, M.B., B.S.Lond.: Three Cases of Acute Perforation of Duodenal Ulcer: Laparotomy: Recovery, B.M.J., March 13th, 1920.

C. P. Symonds, M.D.: Case of Lesion of the Suprascapular Nerve and First Dorsal Root, with Hemisection of the Cord produced by a Single Missile, Proc. Roy. Soc. Med., January, 1920, Sec. of Neurology, 43.

Surg.-Lieut. G. E. Wood, R.N.V.R.: Dentistry in the Royal Navy, *Brit. Dent. Jour.*, March 15th, 1920.

Scenes at the Final Rugby Tie, March 11th, 1920.

Carcinoma of the Stomach.

CLINICAL LECTURE BY R. P. ROWLANDS, M.S., F.R.C.S.

Gentlemen,—I am bringing before you to-day two examples of carcinoma of the stomach.

One of these patients has undergone partial gastrectomy a year ago; the other is too late for any operation.

The contrast between them is very striking.

Case 1: This man, a musician, aged 51, was sent by Dr. Barrie, of Clapham, in February, 1918. He had been ill, on and off, since July, 1917, suffering from indigestion, loss of appetite, and wasting, and his weight had fallen from 9st. to 7st. 3lbs. in a year.

He had seen several specialists on stomach diseases, who had examined and treated him in a great variety of ways.

Medical treatment having failed to ease him, and a swelling having at last appeared in the epigastrium, he was sent to a surgeon, who said it was too late to operate.

When I saw him there was a large pyloric swelling, which, however, was movable both vertically and laterally. There was no evidence of secondary growth in the pelvis or elsewhere. Therefore, although the patient was very thin and anæmic, he was offered the chance of an operation; and this seemed wise especially as there was definite pyloric obstruction which could be relieved by short-circuiting, should re-section prove impossible.

At the operation early in March, 1918, two-thirds of the stomach and the glands above, below and behind it, were removed in one mass, after tying the gastric vessels, which made the operation almost bloodless.

The duodenum two inches from the pylorus was divided and closed, and the side of the jejunum was joined to the open end of the cardiac remainder of the stomach.

The operation was difficult owing to the adhesion of the growth to the front of the pancreas, but it was completed in an hour, and the patient stood it well. He gained about 2st. in weight, and returned to his ordinary work three months later.

Microscopic examination by Dr. Nicholson of the very large ulcer removed, showed columnar-celled-carcinoma.

The patient remained well until Christmas, 1918, when, after working seven days a week entertaining the wounded, and eating large meals rather hurriedly, he began to vomit large quantities twice weekly, and lost flesh.

It was thought the remainder of the stomach had dilated, and a dry diet was suggested. However, the patient got worse and an operation became necessary to correct the vicious vomiting, which was due to a kink at the anastomosis. The two limbs of the loop of the jejunum had been drawn up through the meso-colon, which had contracted round them, the result being that all the bile and pancreatic juice had to enter the dilated stomach before it could reach the distal part of the jejunum.

A lateral anastomosis between the limbs of the loop completely stopped the vomiting, and the patient is now convalescent and rapidly putting on weight.

Case 2: This woman, aged 73, has had indigestion for about six months. She has wasted a great deal, and has been vomiting small quantities frequently.

Anorexia, anæmia and constipation have been marked symptoms, and a large swelling has appeared in the left hypochondrium.

She was sent into the ward with a diagnosis of carcinoma of the colon with obstruction, but there was no distension or visible peristatis of the cæcum, therefore growth of the transverse colon was excluded.

X-ray examination confirmed the diagnosis of extensive growth of the body of the stomach without any obstruction or dilatation.

Therefore, no operation is to be undertaken, and the symptoms have been greatly relieved by dieting and sedatives.

Remarks. It is significant and fortunate that, in the large majority, carcinoma, like simple ulcer of the stomach, starts at or near the pylorus upon the lesser curvature. Significant, because of the undoubted risk of a chronic ulcer becoming malignant; fortunate, because a growth in this situation

(a) Soon leads to obstructive signs of great value in diagnosis;

(b) The growth is often palpable in the epigastrium; and

(c) Is favourably placed for re-section if the diagnosis is made in time.

In a few cases carcinoma commences at the cardia or in the fundus, where radical operation is rarely practicable. Growths upon the anterior or posterior walls near the middle of the stomach are more amenable if they are discovered in time, but this is unusual, for they do not cause obstruction or early symptoms.

Without operation cancer of the stomach is absolutely hopeless. Spontaneous cure is not known, and medicine is of no use except to alleviate the symptoms of inoperable disease. Surely surgery can do better than this if given a chance, but too often the surgeon is not asked to see the patient until the diagnosis has become too obvious and the prognosis is hopeless.

Diagnosis.

Much time is wasted in laborious attempts to arrive at a diagnosis from various laboratory tests. This "scientific and deadly delay" (Mayo) often throws away the opportunity of radical and successful operation. The laboratory tests must be regarded as no more than aids in the diagnosis. For instance, free HCl., although usually diminished, may be found even in excess with early gastric carcinoma. It may be greatly reduced in pernicious anæmia, chronic pancreatitis, or hour-glass stomach. Apart from obstruction, X-ray examinations are not of great value in early cases, but occasionally they may show distortions of shape which are suggestive of carcinoma.

Cancer of the stomach in its early stages does not give rise to symptoms which can be said to be characteristic of the disease. Rapid and progressive wasting, anæmia, pain, anorexia, nausea, and vomiting are suggestive. These, and especially a palpable tumour or obstructive signs, however, indicate an early exploration. Some half-cooked rice and a few raisins are given with some soup in the evening. If on washing out the stomach in the morning any food remnants are found there is clearly obstruction, and although this may be due to a simple ulcer, it strongly indicates an operation both for diagnosis and treatment. *It cannot be too strongly urged that diagnosis to be early enough must frequently be made by exploration.*

Result of Partial Gastrectomy.

In the past operation has been delayed because the immediate mortality is generally supposed to be very high, and the prospect of permanent cure or prolonged relief is believed to be poor.

As regards the immediate mortality, the technique of partial gastrectomy has been so much improved in recent years that the mortality, in good hands, should not be more than 10 per cent., but re-section for definite malignant disease is not likely to show such good results until the patients are sent for operation much earlier than they are in this country at the present time.

In early cases the operation is easy and comparatively safe, whereas in late cases it may be very difficult, prolonged and dangerous. Therefore the careful selection of cases for operation is necessary.

As regards the ultimate results, Mayo states that the patient with carcinoma of the stomach which is sufficiently localised to be removed has at least a 25 per cent. chance of a five years' cure.

Indications for Operation.

The hope of progress and improvement in our results depends on early exploration as soon as carcinoma of the stomach is strongly suspected from the symptoms and signs already indicated under "diagnosis." As it is less than a quarter of the cases come to the surgeon soon enough to allow re-section to be done. Nearly two-thirds are unsuitable for any operation, but in nearly a quarter of the cases an exploration is necessary to decide whether anything can be done.

It is clear that such late explorations are to be avoided whenever possible, for in these feeble patients it is not without considerable risk, therefore it is important to consider the clinical signs which indicate that the growth is inoperable. They are as follows:—

1. Large size and fixation of the growth;

2. The discovery of dropped and grafted nodules of growth in the pelvis on rectal or vaginal examination;

3. Enlarged supra-clavicular glands, especially common on the left side;

4. Nodules of growth at the umbilicus or under the skin of the abdomen;

5. Ascites, indicating peritoneal growth or obstruction of the portal vein;

6. Nodular enlargement of the liver; and

7. Moreover the patient may be too exhausted to stand the operation.

In some of these cases, however, a gastro-jejunostomy may be performed to relieve the vomiting of pyloric obstruction. This operation, however, should not be performed when re-section is practicable, for both the early and ultimate results of re-section are much better, although its immediate risks are somewhat higher. Occasionally a preliminary gastro-jejunostomy may enable the patient to get fit enough for re-section a month later.

Upon exploration the following points indicate that the growth is unsuitable for re-section:—

(1) *Secondary growths in the Viscera*, especially in the liver. The hand is always passed above as well as below both lobes of the liver, for it is not uncommon to find isolated nodules of growth upon the diaphragmatic surface of the liver. A direct local invasion of the anterior edge of the liver is not always a contra-indication, for a wedge-shaped piece may be re-sected with the primary growth. More often an invaded gall-bladder, or even a part of the transverse colon, may be removed. Invasion of the pancreas has been usually regarded as a strong contra-indication, but recent work has shown that portions of the pancreas may be safely removed.

(2) *Peritoneal Infection*. The hand is passed into the pelvis and the small intestine is inspected. If nodules of growth are discovered, it is generally useless to attempt re-section of the primary growth, but an isolated nodule in the pelvis need not necessarily interfere, for it may be either removable or of slow growth, so that prolonged *relief* may be expected from re-section.

(3) *The Size, Site and degree of Fixation of the Growth*. While in many cases cancer of the pylorus may remain long limited to the pylorus itself, it is very liable to infect the omenta and the lymphatic glands around the head of the pancreas, and later to cause secondary growths in the liver and other parts.

Adhesions, too, are very frequently met with between the stomach and the colon, pancreas, or liver. When adhesions are present the immediate mortality of the operation is greatly increased, and this is especially true of adhesions involving the pancreas. The prospects of permanent relief are, of course, much diminished, for the growth follows closely in the wake of inflammatory adhesions. *The more the growth has extended towards the cardiac orifice along the lesser curvature, the less the chance of successful re-section.*

Moderate enlargement of the lymphatic glands is not a contra-indication to re-section, for the glands are very frequently found to be merely inflamed, and they may be seen near a simple ulcer. When the glands are of a large size and adherent or wide spread, it is generally too late to attempt the removal of the growth. In the great majority of cases an exploration should be undertaken before any tumour can be felt, but it is certainly not true that re-section is to be considered impracticable because a tumour is evident, for even the induration around a simple pyloric ulcer may be felt in thin patients.

From a careful consideration of the symptoms, and the results of chemical and microscopical examinations of the gastric findings, etc., the diagnosis should be more frequently made before the growth becomes irremovable; and with this object an early exploration should be undertaken, when the symptoms do not yield to treatment and suggest the probability of the existence of carcinoma of the stomach. The danger of an *early* exploration is very small, although a simple exploration in *late and inoperable* cases carries with it a considerable risk, as shown by the experience of Kronlein and Mikuliez, who had a mortality of about 9 per cent. in such late explorations.

Change of Address.

W. E. Wallis, B.A., M.B., B.C., the Mount East Grinstead, Sussex.

Honours.

C.B.E.

L. H. McGavin, F.R.C.S.

Pupils' Physical Society.—A Meeting will be held on Tuesday, March 23rd, at 8.30 p.m. in the Anatomical Theatre, when Sir George Savage will give a Lantern Lecture on "Mountains and Mountaineering."

Some of my Experiences of the War.

By C. HIGGENS, F.R.C.S.,
Consulting Ophthalmic Surgeon to Guy's Hospital.

[Owing to a misprint in the last GAZETTE, we stated that there were only 270 beds in the County of London War Hospital; actually there were 2,700. —Ed.]

(*Continued.*)

I now come to what has been the principal part of my work since August, 1915.

Plastic Operations of the Eyelid and Adjacent Parts.

Before that date I knew no more about plastic surgery than the average ophthalmic surgeon knows. From time to time I had cases of entropion and ectropion, burns and other injuries of the eyelids and face, but I could count the number in a year on the fingers of my two hands. As I have already stated, my business has been to make up deficiencies in the tissues, so that an artificial eye could be worn, and with that object in view I have performed hundreds of operations, and, before going further, I must say that I owe to Major Gillies, who has been the pioneer in plastic surgery of the face, the knowledge of what could be done. I had no idea of it. I was brought up and weaned on the surgery of the ten years from 1864 to 1873, when I became an ophthalmic surgeon, and I had never attempted the operations which Major Gillies, myself and many others have performed since 1914. Had I or anyone else forty-five years ago done so, we should have been perpetually in the Law Courts for damages for mal-practise and in the case of a death amongst our patients, have been tried for manslaughter; but having had the benefit of seeing what he did, I have done my best to go one better. Whether I have succeeded or not, I cannot say.

I remember his coming to see me operate one day when I had a very bad case of a huge and hideous scar, extending from just in front of the ear through the cheek and into the mouth, leaving the teeth exposed. The facial nerve had been divided. I was thinking about what was best to do with it, when Major Gillies suggested that I should swing the temporal muscle round, dissect up the scar, and pull the muscle underneath it. I thought he he was chaffing, but he was not, so I did the operation under his direction. The result was eminently satisfactory, the deep scar was raised, and eventually became only a white line.

Later I had to treat the opening into the mouth, but that was easily remedied. By paring away the scar tissue and uniting the raw edges very little deformity was left, but the eye which never could be closed on account of the facial paralysis went to the bad, and had to be removed. I have done four similar cases since with equally good result.

I am not writing this paper on the larger operations, of which I have done quite a number. I have turned out several respectable noses, and greatly improved many disfiguring scars, but have had no lower jaw cases. These have never been sent to me, nor do I see that any useful purpose would be served by describing the many shifts and plannings I have had recourse to and given up, so shall confine myself chiefly to the description of operations for making up eyelids and sockets so that an artificial eye can be worn.

I have adopted certain axioms for all operations, which may or may not be of interest and which apply to all classes of cases.

1. Always make up a lesion in any individual by a portion of his own anatomy. To this I make one exception; this is in the case of conjunctiva. I have had most satisfactory results from making up deficiencies in one patient by planting conjunctiva taken from another in whom there was not enough left to be of any service, and closure of the orbit was the only thing to be done. I have done it in several cases, all with success. One of my patients, when he left the hospital with an artificial eye fitted, was the third owner of a piece of conjunctiva removed from a hopeless case to another not quite so bad, where it did no good, and was transplanted to the third man.

2. Never make a flap from scar tissue, and never, if possible to avoid it, plant a flap in scar tissue.

3. Always excise scars completely when covering their site, by undercutting, unless they are very deep, in which case they can be made to help fill up their own cavity by dissecting them up, leaving them attached by one end and turning them back downwards into it, with the raw surface against the raw surface of the undercut.

My methods have now crystalised out as follows (I will take the shrunken socket first):

1. Transplantation of conjunctiva has already been mentioned.

2. Shifting of conjunctiva about in the socket. In many cases of badly shrunken socket there is no real loss of conjunctiva, but it is puckered up and matted together, fixed in bands to scars in the lids, or drawn backwards to scars deep in the orbit. In such cases I detach scars, dissect up the whole conjunctival sac and unravel it till I can smooth it out, next fit it as nearly as possible in its original position, taking care that no two raw surfaces are left in contact, then stuff the socket firmly with gauze smeared with B.I.P.

3. To make up loss of substance. One method I employ is what I call a flap and rope operation. First I open the contracted socket by a longitudinal incision extending from canthus to canthus, and dissect up what conjunctiva there is. Having done this I mark out a flap, large enough to easily fill up the gap I have made, on some part of the face where the skin is normal and unscarred (the eyelids for choice), commencing the flap by a narrower portion of suitable length also made in healthy skin in such a position that it will when its position is altered bridge over any scar tissue that may be in the way and easily clear the outer or inner canthus, then dissect the whole up, plant the broad end or flap into the opening already made in the shrunken socket, suture it accurately to the remains of conjunctiva, then bring the edges of the narrow part together to form the rope.

Where there is no eyelid skin available I take my flap from the temporal or frontal region, the former if I wish to introduce it from the outer side of the socket, the latter if from the inner side, the part to form the rope commencing about half to one inch from the outer canthus if the flap is brought from the temporal region, or on the side of the nose furthest from the inner canthus if brought from the frontal region.

There is one objection to these flaps for making up sockets. The skin is a bit too thick and when all has firmly healed bulges and takes up too much room. This can be remedied by dissecting up the flap on one side, thinning it by cutting away some of its under surface, spreading it out and replacing it. For making up an eyelid, a temporal or frontal flap gives most excellent results.

The after treatment of flaps and ropes is the same whether they are used for making up sockets, eyelids or any other loss of tissue:

Dress them with gauze and B.I.P., stuffing sockets with a plug of it, bandage and leave untouched as long as there is no pain or discomfort, discharge or other reasons for examining them.

At the end of three weeks or a month the operation can be completed (in the case of shrunken socket) by cutting through the rope at the outer or inner canthus, splitting that part of it which is within the palpebral aperture, flattening it out and fixing it with sutures well behind the canthus. The rest of the rope will probably not be wanted, and it should be cut away and its cut base closed up by sutures. But should there be any failure in healing of the wound from which the rope came it should be flattened out and replaced in its original position.

In the case of eyelids, the flap and rope must be treated in the same way, except that there is no fixing behind the canthus, raw surfaces must be sutured together, and superfluous portions of rope removed.

The "sunken" as distinguished from the shrunken socket can also be treated most effectively by the flap and rope. A good thick oval flap should be made from the temporal region and planted into a gap made in the bottom of the socket—in the same way as already described. This method gives just as good results as those obtained from a post and cap made of cartilage, and does away with the extra mutilation caused by the removal of a portion of costal cartilage, the wound of which takes weeks to heal and keeps the patient in bed long after the operation on the socket itself has been recovered from.

I now come to a method which I have only thought of within the last six months, and which will, I think, supersede all others in the treatment of the shrunken socket; but possibly some of my colleagues know all about it.

I know that Major Cruise had it in his mind, because he told me that he had hit upon a way of treating the sunken socket, and asked me to send him a bad case or two if I could. I asked him what it was, and he told me by

"epithelial inlay"; at that time I had already done three cases. I have now done 27, and the results are most encouraging, the greater number being entirely satisfactory and in the remainder there has been a very marked improvement. All were bad cases, and several of them had been treated by other methods with no satisfactory results.

Two things I have learnt from my very small experience. One is to make the inlays large enough; in fact, they cannot be too large. If there are any superfluous portions they can easily be removed later. The other is not to plant them too deeply. If this is done the resulting cavity is not sloping enough, but resembles a funnel with its mouth pointing forwards.

In my earlier cases I shaved off thin grafts with a big knife, but always found it difficult to get them the right size and shape; the knife edge would always come out where it was not wanted to, and the resulting graft was any kind of shape and not of the right size.

I have got over all this by not bothering to make the grafts of epithelum only, but have cut them thicker. The method I have adopted in all my later cases has been to make a pattern of the deficiency to be made good out of a piece of linen, jaconet or any other material that happens to be at hand. Lay the pattern on the skin of the upper arm in any suitable position, and mark it out on the skin with the point of a sharp knife, then dissect up the piece so marked out, taking care to go only just a little deeper than the epithelial layer but never to go through the whole thickness of the skin. By this means I get a graft which is exactly of the size and shape required.

When the separation has been completed I lay the graft on a towel raw side downwards, place on the top of it a mould made of "Kerr" which has been already prepared. The mould has a hole through its centre through which a piece of gut has been passed with a good long piece hanging out at each end; a knot being tied near each end of the mould to prevent it slipping. The mould can then be held in position by an assistant holding the two ends of the gut, so that he does not need to touch it, and his hands are well out of the way. I then fix the graft to the mould by suturing its edges over it. The mould, covered by the graft, is next lifted up by the gut string and placed in the cavity in the socket already prepared for it, pressed well into it, and secured in position by suturing the conjunctiva that is left over it. The gut string is cut inside one of the knots and pulled out. Dressings are applied, and the whole firmly bandaged and left untouched for two or three days, when the dressings are removed and replaced.

At the end of about ten days the sutures keeping the mould in position are cut, the mould taken out, and the hollow which it has filled will be found covered by an epithelial lining.

Well, I think I have written about enough; but in some way, though it may appear a wicked thing to say, I am grateful to The War. From a purely personal point of view, because it started for me new interests and a new professional life; and, better still, introduced me to men all years younger than myself, and many of them Guy's men, alongside whom I have worked and whom I should never have known had it not been for the War, and I do not know that it has made me any enemies.

Then there is another matter which is not personal to me, but concerns the whole medical profession. It is the enormous difference in the relations which have grown up between the two branches, civil and the military. In pre-war days the civil medicals thought very little of the Royal Army Medical Corps, and I think the compliment was returned by the soldiers. I remember one telling a patient on being shown my report "a civilian's certificate means nothing to me." I also remember, and everyone else will remember who has been for a long period connected with a medical school, the class of man who went into what used to be called "The Queen's Service." The Indian Medical was different, was not easy to get into, and many good men joined it.

I know I used to be frequently asked by men what I thought about the R.A.M.C. as a profession, and I used to tell them if they were good for anything they had much better go into general practice in this country and make a few hundreds a year, or even go abroad and strike out a line for themselves.

The only men I ever advised to go into the Army were the confirmed wasters and ne'er do wells, and I pitied the poor Tommies.

The war has changed everything. Civilian medicals and Army medicals have worked side

by side, and have got to know each other. Mutual respect and esteem for each other has sprung up, and all have got to know each other's worth, and I prophesy that those feelings will last for generations.

[Mr. Higgens asks us to state that persistent reports have been circulated to the effect that he has retired, but that there is not a word of truth in these reports. Although he had been doing war-work for four-and-a-half years he had never given up practice entirely, nor has he any intention of so doing. He is at work again, as usual.—Ed.]

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—In your editorial of March 6th you refer to a suggestion that the amount of dental caries in a given district is directly proportional to (a) the number of dental practitioners and (b) the number of tooth brushes in that district. The suggestion, though no doubt humorously intended, is, in the main, correct. As long as dentists suffer their patients to remain in ignorance of the causes of dental caries and continue to allow them to denude their enamel and inflame their gums by the daily traumatic influence of brush, powder or paste, so long will the health of the nation be impaired through a diseased mouth being the rule rather than the exception.

By a curious coincidence, the answer to the problem of the prevention of dental caries is found in the same number of the GAZETTE, where "Child Welfare," by Dr. Sim Wallace, is reviewed. It is some ten or fifteen years since I first heard Dr. Sim Wallace state that the only cause of dental caries that really mattered was the fact that we did not grasp the principle that the mouth cannot be kept physiologically clean except by physiological means, in other words by a detergent diet. Every year of practice since then has helped to confirm my opinion that Dr. Sim Wallace's simple theory is correct. Every year the nation's diet grows less detergent in its effect on the teeth—softer, stickier, more fermentable—and, till the medical profession in its capacity of instructor to the public, stops and ponders whither this hopeless departure from the natural in food is taking us, our teeth and our digestions, so long the occasional dentist may state the obvious in vain. By the obvious I mean that Nature intended that teeth should keep adequately clean through the performance of their proper functions and that the mouth is not part of the face, but of the digestive tract, and to brush it is as ridiculous as to brush the stomach or intestines, though I do not doubt there are many who would do that, too, if they could. "Pyorrhœa," so-called, is nowadays the subject of as much misplaced energy in the shape of scientific research as dental caries. In 99 cases out of 100 it is the outcome of a chronic marginal gingivitis and absorption of the interdental papillæ, which processes have been going on unknown to the patient for years, and are caused by the lodgment of food between the teeth and by the artificial means employed in attempting to remove it. When teeth are brushed in the usual side-to-side or up-and-down way, not only is tooth structure removed and the epithelium of the gum abraded, but particles of the paste or powder employed are driven beneath the gum margin and between the teeth and are a potent contributory cause of "serumal" calculus and "septic pockets." There is only one way to brush the face of a tooth which might even possibly be safe, and that is to brush entirely in a direction from the gum to the tooth, which is much too much trouble for most people.

No brushing will prevent dental caries, since the brush misses nearly all the precise spots where decay is wont to commence. It may actually cause caries at the cervical edge by removing the protective gum and enamel. Mouth-washes, of course, are useless; it being impossible to use them often enough and in sufficient strength without killing the patient. Surgical cleanliness, being impossible, may be disregarded and a physiological cleanliness only aimed at, where the teeth are kept free from fermenting starch and sugar by the scouring effected by masticating plenty of uncooked fibrous food, especially at the end of the meal, and the copious flow of alkaline saliva engendered thereby.—I am, Yours faithfully,

F. M. HOLBORN, L.D.S.

DEAR SIR,— The valedictory address of Sir Cooper Perry, with its subtle and mellowed humanity, must have brought back many memories to Guy's men, "cast out to ultimate isles"; and touched many hearts — days of Pye-Smith, Goodhart, Hale-White, and Shaw; Lucas and Symonds; Lane and Dunn. And as they pass or leave the scene of their life work, we, too, feel we are leaving part of our selves behind.

"Where the Spirit its highest hath led,
All spots, match'd with that spot, are less divine."

St. Margaret's, RICHARD GILBARD.
Dean Road,
Willesden Green, N.W. 2.

DEAR SIR,—I was pleased to see your notes in last week's "Passim" pointing out the importance of Guy's being adequately represented on the Council of the Royal College of Surgeons, and I trust that old Guy's men will carry out your suggestions and obtain

promises of support for Mr. Steward from all the Fellows with whom they are in touch. Medical education as a whole is somewhat in the melting pot at present and Guy's men everywhere must see to it that Mr. Steward is returned to the Council to represent Guy's in the remoulding. A considerable proportion of Fellows do not, as a rule, vote in these elections, so that there is a large field for energetic workers to deal with.—Yours faithfully,

F.R.C.S.

Football.

GUY'S v. ST. BARTHOLOMEW'S.

Inter-Hospital Rugby Cup Tie Final.

In the presence of His Majesty the King, the Cup Tie Match was duly decided at Richmond Athletic Ground on Thursday, March 11th. The parade of students in fancy dress was a great success, and their reception of the King was magnificent and wholehearted. In addition there were many important men present from all the London Hospitals; I hesitate to give their names, lest I should forget to mention some. The responsibility of your reporter on these occasions is great, for it is his duty to convey to Guy's men, the world over, a correct impression of the match.

After both teams had lined up and been presented to His Majesty, the game commenced, Mr. Porter Irwin acting as Referee. At first our forwards played with great dash and kept Bart.'s well down field. However, dribbling hard, Bart.'s soon had us back to midfield, where Davies put in a high punt and followed up. Smuts, the Bart.'s full back, missed the the ball, and bad luck in the bounce prevented Davies securing it. A scrum ensued, the ball passed back to Smuts, and he found touch well up-field. This he did repeatedly throughout the afternoon; his kicking was magnificent in length and direction. The forwards now got the ball out and our three's had a run, but J. A. Krige threw behind Steyn. The ball was soon out again, and Van Schalkwijk cut out a splendid opening for P. J. Krige to open the scoring with the first try fifteen minutes from the start; it was not, however, converted by Neser. Bart.'s forwards, Shaw and Morlock particularly, were very smart on the ball, and a big Bart.'s man—I think it must have been Midge—was always prominent in the line-out. Three penalties within goal-shot were given against us, but luckily none came off. Two or three more times in addition, when well placed, we suffered in the same way. Then Bart.'s had some passing, but this broke down before the ball reached either Thomas or Moody-Jones owing to excellent clearance by Marais, which the latter terminated with with an extraordinary wild pass. After this, plenty of tackling and far too much kicking led up to the end of the first half.

Recommencing one hoped that our three-quarters would get more chances and that we should see less of that everlasting and almost useless short touch finding, for here we had the spectacle of an almost International three-quarter line watching the ball heeled by the forwards and then punted a short way into touch. However, a run came their way at last, and Steyn got off, a second too late; Thomas caught him up and Steyn broke his collar bone in the fall. Reitz came out and filled his place. For some twenty minutes we had a hard time, but all our men tackled well, and once Thomas looked a certain scorer, but Olivier was there and got him into touch. Llewellyn tried a drop, and though Ness-Walker and Cockell got their three's moving nicely on several occasions, the ball never went beyond Llewellyn. Why he preferred the punt instead of giving Thomas a chance or chances one cannot even guess. At length things came our way again, and a starting back movement sent Reitz away, passed in again to J. A. Krige, who was tackled inches out. Then Marais got away, also Doherty. At the critical moment Van Zijl accepted and raced over for a second try which Neser could not convert, though he made a good shot. Fierce was the struggle from now to the end, but nothing more was scored, and Guy's were left victors by the narrow margin of 2 tries (6 points) to nil.

Guy's Team.—W. Olivier, P. J. Krige, H. Graham-Davies, J. A. Krige, C. L. Steyn, F. Bekker, J. Van Schalkwijk, W. H. Doherty, G. E. Kidman, F. W. Reitz, A. H. Shellswell, E. E. Neser, A. Marais, H. Van Zijl, R. R. F. Duncan.

Remarks.—Hearty congratulations to W. D. Doherty and his men on winning the Cup for Guy's. Magnificently did the captain play, and may one add that all backed him up in the pack splendidly, Shellswell, Van Zijl and Kidman particularly so. Olivier was cool and very safe; the three-quarters had not enough to do, and to this to my mind the low scoring is due. Bekker worked untiringly. Van Schalkwijk cut out a couple of brilliant openings, but he might surely have used his three-quarters more. Reitz filled Steyn's place admirably.

CUP FINAL.

At Queen's Club, Wednesday, March 10th, Guy's and London met in the Final of the Inter-hospital Cup. In the preceding rounds London had defeated St. Mary's and Middlesex, while Guy's had accounted for Bart.'s and Thomas's.

Guy's were without their captain, G. P. Lindsay, who had unfortunately fractured his right tibia and fibula in the semi-final against Thomas's. This,

coupled with the fact that earlier in the season Guy's had been beaten twice by London, pointed to the latter as favourites.

Coxon won the toss and elected to kick towards the pavilion. For the first twenty minutes the Guy's team seemed to be all at sea, London doing pretty well as they liked. Following a mis-kick by the Guy's left back, Williams, the London centre forward scored from close in. This reverse roused the Guy's team, and they were soon pressing, and about twenty minutes from half-time, from a pass by Coxon, Trott scored. Ten minutes later Pengelly scored after a good run by Van Geuns. The interval arrived with the score 2—1 in Guy's favour.

The King presenting the Cup to the Captain of Guy's Hospital Rugby Fifteen.

From the kick-off, London tried hard to draw level, and were unfortunate not to score, when their centre forward had an open goal, but shot wide. With the exception of an occasional attack, which

never looked dangerous, Guy's did all the attacking in the latter part of the game. Five minutes from the end Trott headed a goal from a corner kick well placed by Van Geuns. This proved to be the final score, although London made two further dangerous attacks.

At the end of the game the Guy's players were carried off the field by their jubilant supporters to the pavilion, where Sir Cuthbert Wallace, the Dean of St. Thomas's Hospital, presented the cup to Coxon, the Guy's captain.

A pleasing feature of this year's final was the number of Guy's men who turned out to support their team, about 300 of them making the journey to Baron's Court. Through the kindness of Mr. Fagge, G. P. Lindsay was able to witness his team's victory. It is difficult to pick out any player for special mention. Every man played hard, and the greatest credit is due to them for bringing the Cup back once again to the "Spit."

M. Mackeith; C. A. Wakeford; A. W. Riddolls; F. Rayner, P. J. O'Meara, D. H. Couch; R. Van Geuns, R. Pengelly C. Coxon (captain), L. A. S. Trott, J. Rowbotham.

Referee: Mr. Saville.

Notices.

The Annual General Meeting of the Students' Club will be held in the Medical School Buildings on Monday, March 29th, at 4 p.m. Dr. Fawcett will be in the chair.

N. MUTCH,
Hon. Sec. Students' Club.

MEMORIAL TO OFFICERS AND MEN OF THE ROYAL ARMY MEDICAL CORPS FALLEN IN THE WAR.

February 25th, 1920.

Dear Sir,

A Committee representing every branch of the Royal Army Medical Corps has been formed under the Presidency of the Director General Medical Services, and has decided to erect a Memorial bearing the names of all Medical Officers and Men who fell in the War.

It is proposed to place the Monument on a prominent site in London, and if funds permit, to erect replicas in Edinburgh and Dublin. Should any surplus funds remain, these will be devoted to the provision of grants-in-aid to the families of fallen members of the Royal Army Medical Corps.

At present some ten thousand pounds have been collected, but it is estimated that a sum of at least thirty thousand will be required for the erection of Memorials worthy of the occasion.

Subscriptions are being collected by Army Commands, throughout the United Kingdom, but as some difficulty exists in making the project generally known, I am taking this opportunity of bringing it to your notice, and impressing the fact that the proposed Memorial, as including every branch of the Medical Service, naturally affects our profession as a whole, and also many of our fellow countrymen who are indebted to us for aid in times of strenuous need.

At the same time that I venture to draw your attention to the scheme, I must ask you to forgive my importunity should you have already been applied to, or responded to a request for your co-operation.

Yours faithfully,
G. H. MAKINS, P.R.C.S.,
Lately Consulting Surgeon to the British Expeditionary Force in France

Subscriptions should be sent direct to the Treasurers of the Fund, Messrs. Holt & Co., 3, Whitehall Place, London, S.W. 1, marked R.A.M.C. Memorial Fund.

Reviews, etc.

Home Exercises and Spinal Curvatures. By Richard Timberg (Messrs. Heinemann) 2nd edition, price 6s. net.

Dr. Timberg points out in Chapter 3 of his book that the "home exercises" he advocates are by themselves likely to have a beneficial effect in spinal disease of musculo-ligamentous origin, but he lays emphasis on the fact that the best results are obtainable when they are used in conjunction with massage and other more efficient exercises conducted under the supervision of an expert. As to the exercises themselves, they are excellently illustrated by numerous photographs throughout the book; they are quite simple to carry out in the home; the principles which underlie their use are mechanically sound, and there can be no doubt, we think, that they are bound to exert a beneficial effect on the course of mild spinal deformities. We were glad to observe a protest registered against the long hours of sitting on school benches, which always induces bad posture and eventually leads in some cases to actual deformity. An interesting point raised by Dr. Timberg is the influence of games like hockey and golf, which are played in a one-sided position, on the causation of spinal curvatures. At the present time, so-called remedial and medical drill has long been in vogue at many secondary schools, and one cannot help thinking that the adoption of special exercises in elementary schools as well, for the benefit of physically defective children would have far reaching effects on the general well-being of the Nation as a whole.

Births.

BILLING.—On March 1st, at Denholm, Chingford, the wife of E. Billing, M.A., M.R.C.S., L.R.C.P., of a daughter.

BROMLEY.—On the 16th February, at the Warden's House, Guy's Hospital, the wife of Lancelot Bromley, M.C., F.R.C.S., a son.

GREENFIELD.—On March 7th, at 2, Griffith Street, Rushden, the wife of D. G. Greenfield, M.D., F.R.C.S., of a son.

SANDISON.—On Monday, March 1st, at 21, South Hill Park Road, South Croydon, the wife of Alexander Sandison, M.B., of a daughter.

Death.

WORNUM.—On the 18th February, at Farmingham, Kent, George Porter Wornum, M.R.C.S., of Hampstead, London, aged 62 years.

Ed.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

OWING to the recent victories of the second eleven Association and the second fifteen Rugby football teams at the Inter-Hospital cup ties, two more cups have been added to our collection. This is extremely satisfactory, and we hope that the addition to our Clubs' Union furniture will be an enduring one. In passing, we feel bound to compliment the first fifteen on their magnificent display against Blackheath on March 24th. Writing about the match, the *Sportsman* says:—"It is true that Blackheath won, but as far as the actual play went they could hardly be called the better side . . . so a hard struggle was decided by a couple of successful kicks at goal." Considering that Blackheath had over half-a-dozen Internationals playing against us, their victory by a margin of only six points is a sufficient tribute to the splendid efforts of the Guy's side.

A FEW days ago a Bill proposing to do away with vivisection experiments on dogs came before Parliament. Fortunately for the public, the Bill was talked out of the House before a closure was possible, and the interests of research were safeguarded for a few more months. No doubt the Adversaries will be hard at work again soon and the welfare of the public will once more be in danger.

The medical profession owes a debt of gratitude to Sir Watson Cheyne and Captain Elliot for their admirable speeches in favour of the freedom of the experimental worker. Captain Elliot's remarks on the great advances made recently on the pathology and treatment of diseases of the heart made a deep impression on the House, and though in the ordinary way we do not approve of somewhat premature announcements of possible cures, we think that in this case Captain Elliot was quite justified in announcing the almost realized dreams of the research worker to the world.

Meanwhile the man in the street, blind as ever to his own welfare, proceeds on his even way and leaves matters to take their own course. During the last few years the Research Defence Society has been doing very good work but their scope is hardly wide enough to cope with the emergencies of the immediate future and it becomes necessary to carry on a much more extensive propaganda which shall place the true facts before every man and woman, whatever be their interests or station in life. Let us hope that some action will be taken by the medical profession in this matter.

England, of course, has always been a happy hunting ground for cranks. Besides the antivivi-

sectionist group there are the antivaccination societies, who are helping to undermine the foundation of our nation's health: on going to press we learn that already twenty-nine cases of small-pox have been reported in the eastern counties. Largely owing to the activities of Stephen Paget and his disciples, a large proportion of the population in this country is unprotected by vaccination, and—to use the late Sir William Osler's simile—the tinder is ready and the spark is kindled. Whether the spark will flicker and die out, or whether the tinder will burst into flame, one does not know. In any case, we hope that the people will learn their lesson and cease to be duped by the colossal presumption of these ignorant theorists who preach a false doctrine to their own satisfaction but to the ultimate detriment of fifty millions of men and women.

We had the pleasure of being present at Sir George Savage's address before the Physical Society on "Mountaineering" the other day. The lecture was illustrated by many magnificent lantern slides of the Swiss and Italian Alps, and it is unnecessary to add how deeply interested the audience were in Sir George Savage's remarks. It is a pity that so few of our staff—many of whom enjoyed the privilege of ascending the intellectual heights with Sir George as guide—were able to attend the meeting.

It was interesting to note that among the guests present at this meeting was a large number of Guy's nurses. This is the first occasion which we can remember on which nurses were allowed to attend a hospital society meeting, and we can see no reason why it should be the last. We think that the Debating Society, at least, should be allowed to throw open its doors to any of the nursing staff who care to attend its meetings.

Why the Debating Society, on its Ladies' Night, should prefer to limit its invitations to the students of Royal Free Hospital and Bedford College we do not know. We think it sheer hypocrisy to talk about the sterling qualities of our nurses and the good work that they do in the hospital, and then to give a grudging invitation to our sisters and bar the door completely to the rank and file of the nursing staff. I am tempted to quote the words of the Diogenes of Devonshire Place, but no doubt most of my readers know them already.

We understand that Mr. C. P. Symonds, M.D., M.R.C.P., has been appointed Assistant Physician to the Department for Nervous Diseases. This appointment will arouse universal satisfaction; we offer Mr. Symonds our congratulations.

It was with great pleasure, too, that we heard of Mr. Winston's appointment to the post of Assistant Clerk to the Dean in place of Mr. Blott, whot has resigned. Recognising as we do Mr. Winston's organising ability, we think that a better choice could hardly have been made.

Of course we are sorry to lose so hard and loyal a worker as Mr. Blott, who, needless to say, takes with him our very best wishes.

Appointments.

Alan H. Todd, M.S., B.Sc., F.R.C.S., to be Honorary Consulting Surgeon to the National Truss Society, in succession to the late L. A. Dunn.

Russell John Reynolds, M.B., B.S., to be Hon. Radiologist to the (1) National Hospital for Paralysed and Epileptic, Queen Square, W.C., and (2) Bethlem Hospital; also Radiologist to the (1) Ministry of Pensions, and (2) Lambeth Infirmary.

W. R. Reynell, M.D., M.R.C.P., to be Physician to out-patients, West End Hospital for Nervous Diseases.

Circumcision.

ABSTRACT OF CLINICAL LECTURE
BY C. H. FAGGE.

Gentlemen,—I had for some time thought of discussing this subject with you, and my thoughts in this direction were finally crystallised into action by the remark of one of my friends in practice that he always performed this operation before the nurse left the house on male infants whom he had brought into the world. It seemed to me at the time that the least one could say about such a practice was that it was rather hard luck on the infants, and I shall attempt to show that it is also definitely to their disadvantage.

I have asked several friends in general practice to give me their views and as these remarks will appear in the Gazette I am in hopes that other old Guy's men will be sufficiently interested to criticise my conclusions, particularly if their point of view does not coincide with mine.

One of my correspondents writes as follows: "I am setting forth the impressions that I have culled from my practice; when I was at hospital I had drilled into me all the ins and outs of detailed operative treatment of strangulated hernia, and I have only had occasion to operate upon three cases, whereas I was told nothing concerning circumcision and its advisability, and I have now unfortunately done some 120 of them. The dictum concerning circumcision in practice at present is, operate on the boy whilst the nurse is in the house, unless there is any contra-indication, not because it needs to be done, but because it may save trouble of some kind in the future. The greatest advocates seem to be the nurse, who, of course, gets an extra fee, and the father who has discussed the matter with his learned friends in the train morning and evening; the mother is the only being who seems to keep a level head in the matter, and she is swayed by her own sentiment and does not see why it should be done to obviate doubtful trouble in the future. The nurse is convinced it ought to be done because the prepuce cannot be drawn back over the glans penis; to point out that this is a normal condition and that as the child develops the prepuce will stretch and overcome the so-called abnormality is to display one's ignorance. Another reason given is that the child screams when the urine is passed, but in such cases the urine is very highly coloured and stains the napkins. Too high concentration is, in my opinion, the cause of this, which clears up if weak barley water or plain water is given once or twice daily."

These two supposed reasons for circumcision contain the gist of the whole matter. In surgical text books phimosis is stated to be the chief indication for operation; this may be congenital or acquired, the latter being a result of several attacks of inflammation which possibly have been superimposed upon some slight congenital narrowness of the preputial orifice. But let us confine our attention to the congenital type; for this to be present and to give rise to screaming during micturition the preputial orifice must be narrower than the external urethral orifice in the glans. This statement is solely one of hydrostatics and a simple experiment will show that there is no delay in outflow or obstruction at the orifice of a pipe when that opening is no smaller than any other part of its lumen. If the preputial orifice is smaller than the external urethra, then there will be delay, the prepuce will balloon and phimosis is present; but if there is no ballooning there is no phimosis and the operation of circumcision is not indicated.

I quite admit that if the preputial orifice is narrowed then the prepuce is ballooned when the patient tries to micturate, and much straining may be a factor in the maintenance of a hernia. Phimosis, then, is the narrowing of the preputial orifice to such an extent that it is smaller than the urethra. We have all learnt that the urinary meatus is the narrowest part of the urethra.

The mother who brings her child to Surgical Out-Patients and says, "Please, sir, he wants circumcising," is very easily dealt with by a card for minor operations, but it is not surgery. If you are argumentative you say "Why?" and then she will tell you that he strains when he passes his water, and if you then observe him passing his water, which he will probably do as every child passes his water if he is stimulated by having his clothes taken off in a cold room, you will probably find that he has no ballooning of the prepuce at all.

Now to pass to the other reason for circumcision. The prepuce of a newly-born boy is not retractable. The main function of the retraction of the prepuce is to expose the glans, the prepuce being insensitive and the glans

being sensitive. There is no physiological reason for the exposure of the glans until after puberty. If you attempt to expose the glans of a newly-born boy you will find usually that it is impossible to do so, and it was never meant to be done. Text books pay much regard to adherent prepuces. Yet, I believe the prepuce is naturally adherent in childhood, and I cannot think that the degree of adhesion which occurs in ninety-nine out of a hundred male infants can cause any abnormal symptoms. One surgical text book attributes everything from convulsions to masturbation to smegma behind an adherent prepuce. I was an Out-Patient Surgeon some fifteen years, and I never had any reason to believe that retained smegma had anything to do with any pathological states.

It is agreed that phimosis, if present, may lead to trouble. It interferes with micturition and should be dealt with, otherwise it may lead to paraphimosis. If the boy is taught to retract the prepuce or if he does it out of a spirit of inquiry, he may get paraphimosis when his moderately tight preputial orifice is retracted behind the glans which swells and makes it irreducible. This is always an indication for circumcision. Both these things refer to congenital phimosis, but it may be acquired though nearly always it is the result of a slight degree of congenital phimosis, and if this be admitted a wider application of early operation might be urged.*

Acquired phimosis may be the result of—

(a) Congenital.

(b) Cicatrisation of a sore or repeated balanitis.

(c) Long prepuce with splitting or soreness.

A chancre of the prepuce or a soft sore may result in acquired phimosis. To any other cause a certain degree of congenital phimosis predisposes.

A long prepuce *per se* is no disability. I am quite willing to admit that circumcision is theoretically a good operation from the point of view of cleanliness, but a prepuce which has never been retracted and that has not got septic cannot be a cause of uncleanliness. A prepuce which is long and which during adult life is easily split, becoming torn and sore, or which during childhood becomes sore, cracks, and then dermatitis spreading to the thighs, is an indication for circumcision, and apart from this, a definite phimosis, in my opinion, is the only indication for circumcision in childhood.

One practitioner writes: "There are two conditions for which I advise circumcision—(1) pin-hole opening with real difficulty in micturition (this is rare); (2) long prepuce which is constantly wet and inflamed and causes secondary infection of thighs, etc."

A few words about the multitude of conditions in which circumcision is advised in some text books. One of the things constantly stated is that circumcision will tend to relieve and end in the cure of an inguinal hernia in a small child. I tried this in many cases of hernia at the Evelina and never saw any on whom it had any favourable influence.

I have never seen any evidence that nocturnal enuresis is influenced by circumcision. The hypothesis is that if smegma is retained it becomes irritating and predisposes to enuresis. It was the custom at the Evelina twenty years ago to circumcise all small boys with enuresis, but there was no evidence that they were less wet afterwards than before, and, of course, nocturnal enuresis is not proportionately uncommon in small girls.

Then there is the question whether masturbation is influenced by circumcision. I do not gather from my experience that masturbation is less common in the circumcised than in the uncircumcised. I should like to speak for just a minute on the subject of masturbation, and hope I shall not be accused of making light of a bad habit. It is a practice which a large number of men have had as boys in early puberty, and usually originates in a natural spirit of curiosity. I find that many adults, when patients for remote conditions with no relation to genital organs, attribute their lesions to their early practices; this is, to my thinking, a great pity. A medical man who has a large practice among Jews told me it is not less common than among non-circumcised children, and one of my correspondents tells me that it is very common in the boarding schools in his district.

If masturbation is to be regarded as an indication for circumcision it is usually a "maternal" one, by which I mean that the mother is generally the reason when she thinks the boy does abuse himself, for she advocates cir-

*See letter in *B.M.J.*, March 27th, 1920. For such cases dilatation is advocated, and my own experience has shown me its value in slight cases.

cumcision with the idea that it will prevent bad habits. It only draws his attention to the fact that he has an irritable organ, and this intensifies rather than diminishes the trouble.

One doctor wrote to me and thought that circumcision, by producing a certain amount of hardening of the glandular surface, might thereby possibly prevent or diminish its liability to infection by venereal disease, in the form of sores either soft or hard. I believe it is a fact that chancres of all kinds are as common among circumcised as uncircumcised men.

I have been unable to collect any evidence that circumcision is any use in the treatment or prevention of hernia, enuresis, masturbation, or venereal disease. I will now just read the rest of my first correspondent's letter: "The father talks vaguely about preventing venereal disease by circumcision; the schoolmaster is convinced that nocturnal enuresis is cleared up by snipping the foreskin, both fallacies. I am convinced that the dictum should be don't circumcise unless there is some special indication for it. I have come across three cases in which the doctors have lost their respective reputations with their patients over the bad results of this operation. It is the easiest operation, but yet, I think, the most badly done of all, partly because it is done in surroundings not aseptic, and it is difficult to keep the parts quite clean and free from contamination. Too much skin or too little skin is sometimes removed; not enough mucous membrane is removed, with subsequent adhesions; but the most persistent after effect which I have to deal with is when the delicate glans is wrapped up in gauze and a napkin for some days after. The friction that is natural to the parts owing to their mobility damages the epithelium in the region of the meatus; infection takes place and a very localised meatal urethritis occurs which is very troublesome to clear up, and unless treated with a probe and Ung. H.O.F. frequently and persistently gives rise to a good deal of pain, discharge with blood, and sometimes retention with temperature, a condition I have not yet seen in an uncircumcised child.

I once operated upon a boy to please the father and removed the foreskin. It was done with aseptic precautions, the best that the circumstances would allow. It unfortunately went septic with the stitch that controlled the frenal artery, a contact impetigo occurred on the thigh and for the next two months I was treating a generalised impetigo, and the child all but died from septic absorption, D. and V.

I have been very interested in the question of masturbation, and as we have several boarding schools in this district I have been inquiring of the masters of the frequency of it and they tell me it occurs in about 80 per cent. of the boys, and that there is no difference between the circumcised and non-circumcised. So frequent is it at one school the boys are not allowed to have pockets in the trousers. I have come to the conclusion that the reasons for removing the foreskin are so small that the operation ought to be treated more seriously and not advocated in a general way, but as this with removing "T's and A's" is the total repertoire of some doctors it will take some time to accomplish. I would also like to add that in some boys I have removed the foreskin to see if it would stop the development of a hernia that had started, but I now remove the hernia instead, which is the right thing to do."

My second correspondent's views on these question are as follows: "First, I have seen nothing to make me think that the prepuce before puberty should be easily retracted."

I should say that this is from an old friend of mine for thirty years, and it was from him that I learnt this.

"Of course, nearly all prepuces can be forcibly made to expose the glans, but I see no object in doing this. The small amount of secretion normally present never seems to cause irritation, and I do not see the necessity of meticulous cleanliness. There are two conditions for which I advise circumcision. . . . I have seen only poor results from circumcision for enuresis, which is, I suppose, the commonest reason given—if one is given—for the operation.

I have some parents who wish it done because they think it makes masturbation less likely. It would be difficult to prove or disprove this, but I have not seen anything to make me think it has any effect."

Let us now pass on to the consideration of the right way to carry out this operation, and in doing so I shall attempt to point out how bad results, which seem to me unduly common, arise and how they may be avoided.

I assume that this criticism of the results of circumcision cannot be individual or new, for

in the Guy's Hospital Reports for 1892 the late Mr. Davies-Colley wrote a short paper on this operation in which he pointed out that "a great deal of discomfort, and even serious injury, may result from certain mistakes." He goes on to describe in detail a method which he had practised for some years. Most of his pupils have, no doubt, followed his method, and as it seems to justify his contention, and to avoid the comon evils which ensue from a badly performed operation, I shall briefly enumerate its essentials.

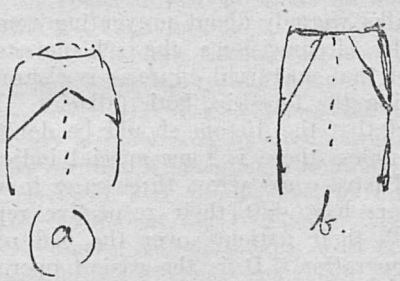
The main principle is that a pair of dressing forceps is placed over the dorsum of the penis midway between the corona and the meatus when the blades are brought together so as to push the glans back out of their grip and to grasp the front part of the foreskin obliquely so as to leave a point below at the frenum; when the prepuce anterior to the forceps is removed, a "V" shaped piece of skin remains on the under surface, which later covers the raw surface below the penis where the glans is deficient.

I would here point out that care must be taken before the anterior part of the prepuce is cut away that the dressing forceps are held firmly closed in front of the glans as otherwise this may be injured.

Burghard (Operative Surgery) thinks that by this method the under surface in the region of the frenum may not be adequately covered, but from considerable use of this method I venture to disagree with this view if Davies-Colley's directions are carefully followed.

Burghard suggests that to ensure a complete covering of skin at this spot the line of incision should not involve the whole circumference of the preputial orifice (Fig. a), but should leave a narrow uncut margin of skin at its lowest part, *i.e.*, for about one-eighth of an inch on either side of the frenum (Fig. b). This would appear to have the advantage of avoiding any division of the frenal arteries and consequent bleeding, but appears to me to leave too much tissue at this spot which must remain redundant and form a blob which is one of the results from a cosmetic point of view which has always to be avoided. To my thinking Davies-Colley's method is inclined to err in this direction rather than in the opposite one, as suggested by Burghard.

After the forceps have been removed and the bleeding vessels taken up, the mucous surface of the prepuce is trimmed so as to leave a fringe of about a quarter of an inch around the corona. Now in doing this, one has to avoid two evils: the commoner is that too much of this mucous surface is cut away and the penis is flayed so that no fringe of prepuce is left to cover the sensitive papillæ of the corona; this evil results either from removing too much skin or too much mucous surface, usually the latter. But the effect of removing too little of the mucous surface is equally or more disastrous, as I have seen on several occasions, for if the mucous fringe be left too long, the prepuce will again come forward in front of the glans, and as healing takes place a tight ring is formed at the orifice resulting in a worse phimosis than that for which the operation was originally undertaken.



A secondary circumcision when this has happened is quite a difficult matter, and great care has to be taken in avoiding injury to the glans which is close behind the constricting band; it is best to make a longitudinal incision on the dorsum through the prepuce into the space between this and the glans when the exact relation of parts can be definitely made out.

As I have said ,it is usual to cut away the mucous surface too freely; as a result too narrow a fringe is left to enable it to be sutured accurately to the skin edge. When this is done in an adult much discomfort ensues particularly when the organ is engorged as in hot weather owing to the exposure of the corona and its resulting friction by the clothes.

It has always been my practice to insert at least three sutures, of which two are dorso-lateral, bringing the fringe of mucous surface into close apposition with the skin; these are not essential in infants. The third is a mattress stitch which both brings the inferior point of skin forward to cover up the raw frenum and also includes the frenal arteries from which hæmorrhage has been controlled by torsion.

A final word of warning as to dressing: it is a custom of long standing to prepare a narrow roll of gauze and wind this around the area of operation; if this is done the meatus must never be covered.

If the gauze roll is used, the meatus must be protected from becoming occluded by blood, etc., by being smeared with vaseline; also the greatest care must be taken that the gauze bandage is so loosely applied as to permit of a certain amount of swelling which naturally occurs after this operation even on the small parts of infants. Never attempt after this or any other operation to cover up imperfect and careless hæmostasis by the application of a tight dressing. When as after out-patient operations the patient has to be carried home a gauze roll is probably the best dressing, but when the operation has taken place in a private house and no skilled attention is constantly available, a cold wet lint dressing is preferable. This can be soaked off in a warm bath which is safely given on the day following the operation and repeated daily; a hot boracic fomentation has much favour after the first twenty-four hours.

Perhaps my experience of eighteen years as an Out-Patient Surgeon here and at the Evelina was unfortunate, but I lost two circumcisions, one from sepsis and the other from reactionary hæmorrhage in a bleeder; so that I regard the operation as more grave than that of tonsillectomy with which I had no fatalities to my knowledge. I mention the above to warn you that no operation must be urged as absolutely free from risk.

Papers by Guy's Men.

J. E. Scales, M.R.C.S., L.R.C.P., Note on a Tuberculous Cow.—*B.M.J.*, March 20th, 1920.

Sir Charters J. Symonds, K.B.E., C.B., C.M.G., M.S., M.D., F.R.C.S., A Note on the Later History of Four Cases of Total Laryngectomy.—*Lancet*, March 20th, 1920.

Alan H. Todd, M.S., B.Sc., F.R.C.S., Dislocations of the Shoulder-Joint, *The Practitioner*, March, 1920.

John D. Malcolm, M.B., C.M., F.R.C.S., Appendicitis without Protective Stiffening of the Abdominal Wall.—*B.M.J.*, March 27th, 1920.

Guy's Hospital Dental Society.

The twenty-first annual dinner was held at the Connaught Rooms, Great Queen Street, on Saturday, February 21st, the President, Mr. F. Bocquet Bull, being in the chair. The company numbered over two hundred.

After the loyal toasts had been drunk, Mr. Sidney Spokes, Dean of University College Hospital Dental School, proposed the toast of "Guy's Hospital and Schools." He said that Professor Keith had recently drawn attention to evolution of the family, the tribe and the nation; he (the speaker) came from a tribe on the north bank of the river and was proud to visit the tribe of the south, with whom they were in friendly rivalry. He mentioned remarkable Guy's men of former years, Bright, Addison and others, who had given their names to numerous diseases. He coupled with the toast the name of Mr. H. L. Eason, C.B., C.M.G., the Superintendent of Guy's Hospital, who he had no doubt would maintain the glorious traditions of Guy's Hospital.

Mr. Eason, in reply, referred to the fact that during his military work he had everywhere found Guy's men doing first-class work. The best dentist in Egypt was a Guy's man—Captain Campion, whose consulting hut was the fashionable military rendezvous. The most distinguished dentist was Col. E. B. Dowsett, but it was not as a dentist that he gained distinction out there, but in a different capacity, for if a man wished to gain distinction in the Army he had to leave his own job and become a square peg for a round hole. Col. Dowsett had done splendid work. He felt that Mr. Hopson, who represented not only Guy's but also the whole dental profession, should be responding to the toast. He was proud that Guy's had accepted no Government Grant, and stated that 222 medical and 249 dental students had entered the School since the Armistice. Furthermore, he had lately had an appeal from St. Mary's Hospital asking for the surrender of certain fire appliances captured during a recent "rag." He thought, therefore, that Guy's was doing very well.

Mr. J. Lewin Payne proposed the toast of the Visitors. The motto of the Hospital was "*Dare quam accipere.*" That motto was true of them as workers in that great Institution, and it was equally true with regard to their visitors that evening. He mentioned Mr. Spokes, Mr. Dolamore, and lastly Mr. R. Lindsey (the recently appointed Dental Secretary to the British Dental Association).

Mr. Lindsey, in reply, referred to the Edinburgh Dental Hospital, with which he had been connected. This institution had been called "Guy's Hospital"

out of compliment to its principal ornament, Major Guy. He trusted that every Guy's man would feel it his duty to join the British Dental Association. He was sure he was voicing the sentiments of all the guests in thanking the Society for their hospitality.

The toast of "The Chairman" was then proposed by Mr. W. H. Willis (Hon. Sec.), who regretted that he lacked the Celtic fervour of his predecessor. He said that their Chairman occupied three honourable posts: he was their President, the Resident Dental Officer, and Dental Surgeon to the Children's Department. In the latter capacity, the Chairman required warning. At present many students were married men, and when he addressed them on the temporary dentition he was speaking to experts. The post-war student at the Hospital had inherited the reputation of Guy's without being familiar with all its traditions. Their Chairman had been a great help to them all in living up to these traditions to-night. He was in every sense "a good fellow."

The Chairman, responding, said we lived in an age of unions, and to-night were met in the best kind of union, a re-union embracing the Senior Staff Surgeon and the youngest student.

As the Isle of Wight curate expressed his pleasure at seeing so many old Cowes faces at the mothers' meeting, so he was glad to see so many old Guy's faces.

He thanked Mr. Willis and them all for the way this toast was received.

The success of the evening was enhanced by the delightful singing of Senor Jose de Moraes, the humour of Mr. Willie Rouse, and the admirable playing of Mr. Val Lane's orchestra.

Guy's Hospital Cricket Club.

The annual general meeting was held on Monday, March 15th, at 1.30 p.m.

Mr. C. H. Fagge occupied the chair.

The business was the election of officers for the coming season. By a unanimous vote Mr. C. H. Fagge was re-elected President..

First XI.—Captain, G. D. Shaw; Vice-Captain, T. Wooldridge.

Second XI.—Captain, V. D. S. Thomas; Vice-Captain, D. Eglington.

Hon. Secretary and Treasurer.—L. B. Helder.

Committee.—E. H. Rowbotham, R. C. May, F. J. Biddle, G. Muir Smith, G. P. Lindsay.

L. B. HELDER,
Hon. Sec., G.H.C.C.

Correspondence.

To the Editor of Guy's Hospital Gazette.

NATIONALISATION OF HOSPITALS.

Dear Sir,—Your "Passim" note on this subject raises two very interesting problems. You, rightly as I think, recognise that adequate hospital provision for the country cannot be secured by voluntary effort unaided, and propose that the public authority should (1) provide additional hospitals, and (2) give financial aid to existing hospitals and, I suppose, possibly to others that may hereafter be established by private philanthropy. Both these steps require careful safeguards if we are to avoid a very rapid drying up of the springs of philanthropy and the complete disappearance of the voluntary principle from our hospital system.

In this connection it is interesting to consider the effect on our voluntary schools of the intervention of the State in the provision of elementary education. Here the two types of school run side by side because large numbers of the public desire to maintain a particular feature in education (namely sectarian religious instruction) which is not provided in the State Schools. As a result there is sufficient differentiation between the provided and non-provided schools to enable the upholders of the voluntary system to make an effective appeal for support from a section of the public. Those who desire to maintain the voluntary system in hospitals must endeavour to secure that provided and non-provided hospitals shall present at least sufficient differentiation in scope and aim to enable the non-proivded to justify an appeal for support from philanthropists. Fortunately this is quite feasible. The type of hospital for which there is the greatest need at the moment is that which recent writers on the subject of hospital reform have called "primary hospitals," and the administration of which is based on existing Cottage Hospitals. Their essential feature is that there is no fixed staff, but that all practitioners in the neighbourhood are entitled to send in their patients and retain them under their own care. There is urgent need of such institutions in all parts of the country, in urban as well as rural districts. Groups of these hospitals established by State or municipal enterprise should be affiliated to some adjacent voluntary hospital of the existing type fully staffed by specialists or consultants so that the transference to and fro of suitable cases could be easily arranged. Such hospitals would prove a much needed relief to the existing voluntary institutions, and at the same time would perform such a different rôle as not to lead the philanthropist to withdraw his support from the older institution on the plea that as the State was providing some hospitals, it might as well provide them all.

It is hardly likely, however, that the relief afforded by this new type of "primary" hospital would enable existing institutions to meet the increasing cost of maintenance, and whilst I agree with you that it would be wise for these voluntary hospitals to seek or accept assistance from the rates and taxes I do not believe that a payment in proportion to the amount of work done would prove to be the most suitable method of subvention. Block grants of this character would almost inevitably lead to extravagance and to a rapid falling away of subscriptions and donations. A better plan would, I think, be that which used many years ago to be called the Australian system,though I do not suppose it originated in that country. It is a simple scheme whereby the State guarantees to contribute to certain hospitals, submitting to Government inspection, a sum having a direct proportion to the the private pecuniary support the institution is able to secure. Such a system encourages the institution to maintain a high standard of efficiency and makes a strong appeal to the subscriber who feels that his contribution will extract an equal or even larger sum from the public purse. Under such a scheme your suggestion that the contributing public authority should nominate one or more persons to the governing body would obviously be appropriate, and if this were done we might even some day find a woman appointed as a Governor of some of our great London Hospitals.—I am, yours sincerely,

LAURISTON E. SHAW.

12, Park Square West,
28th March, 1920.

BLOOD-PRESSURE DURING SURGICAL OPERATIONS.

Dear Sir,—The communication by the National Anæsthetic Research Committee of America, published in the Gazette of March 6th, raises a number of debatable points. There can be no two opinions as to the value of systematic observations of blood-pressure and pulse-rate during the administration of anæsthetics, but it is remarkable that the authors of the communication made no mention of observations during the hours following the completion of an operation. It was neglect of these later observations which delayed so long the proper appreciation of the effects of certain anæsthetics in the genesis of "operative shock." I have notes of cases in which amputation of the thigh was performed under ether anæsthesia and the blood-pressure fell only a few millimetres during operation (in some it was actually higher at the end) although the latter was prolonged over thirty or more minutes, and it was not until an hour after the patient had returned to bed that big falls of pressure were registered. Moreover, if death occurred it was not as a rule until two or three hours after operation. With chloroform anæsthesia the fall of blood-pressure would be still further delayed but the termination was more commonly fatal. It was a study of the post-operative blood-pressures and pulse-rates which revealed the advantages of gas-oxygen anæsthesia in war surgery, and led to the saving of many lives.

Under the heading "Blood-Pressure Rules," the authors state that under no circumstances does one expect to see an elevation of blood-pressure during operation. In my experience it was common for the blood-pressure to rise during the first fifteen or twenty minutes of an ether vapour anæsthesia. With regard to their three degrees of Circulatory Depression they say "A ten to fifteen per cent. increase of pulse rate without change of pressure" is *Safe*: this rule requires a good deal of qualification; I found that a moderate rise of pulse rate was a more serious indication than a moderate fall of blood-pressure . The statement that relaxation of the abdominal muscles cannot be obtained by general anæsthesia without diminishing the tone of the heart muscle requires confirmation; its correctness is at least probable and the indication would seem to be for more extensive use of local anæsthesia for the production of abdominal relaxation, especially in operations on the upper abdomen.

There are some half-hearted references to diastolic and to pulse pressure. I recorded diastolic as well as systolic pressures in all my cases, and came to the conclusion that changes in the pulse-pressure did not give nearly such a delicate indication of the patient's condition as did changes in the systolic pressure or in the pulse-rate.

The object of the Anæsthetic Research Committee is to reduce the mortality associated with surgical operations. Routine blood pressure records will not be kept except by a few enthusiasts, but there is no reason why it should not be made a practice at the hospital to record the pulse-rate every five minutes during severe operations, and every half-hour for three hours after the patient has returned to bed. If such records were made and discussed they would aid both surgeons and anæsthetists to avoid subjecting their patients to unnecessary risks.

GEOFFREY MARSHALL.

LOCKING THE STABLE DOOR.

Dear Sir,—G.H.F.G. has written so good an article that it is desirable that his fallacies should not pass uncriticised.

1. The case of the medical man compelled to disclose venereal disease in a patient by a Court: his comment is "Why" would this deter patients from seeking advice? Setting aside the breach of faith in such a course after the repeated assurance that this would not be disclosed, and the repeated inducement to sufferers to seek treatment on the

ground of that obligation to secrecy, does he (G.H.F.G.) really believe that patients do not insist on secrecy? Of course, he knows better, or he has never done any general practice.

2. "Prostitution," he says, "will be with us so long as the lady clerks' wages average 35s. a week"! Really! Then prostitution is merely an economic necessity. Does he really believe that equal wages would eliminate prostitution? Do the prostitutes come from the chair makers of Cradley Heath and the drudges of the lodging house?

He cannot be ignorant that a large number of street walkers originally came from respectable families in comfortable circumstances.

With the rest of his letter I am in complete agreement, but must plead ignorance of who the Napoleon of Notting Hill was and what he said. Can he be G.H.F.G.?*

T.M.B.

*[No!—Editor.]

Dear Mr. Editor,—I append the copy of a letter sent by the Earl of Cromer to Dr. J. H. Drysdale, as President of the United Hospitals Rugby Football Club. The gracious message of His Majesty the King contained in the letter was read at a special meeting of the members of the "Rugby" team held on Friday last, March 19th.

The attendance of His Majesty at our Final Cup-Tie rendered March 11th last a red-letter day in the annals of hospital football, and the message the King has transmitted to Dr. Drysdale will be read and most cordially appreciated not only by old Guy's men in this country but by the many loyal "Guy's" sons scattered throughout His Majesty's Dominions overseas.—I am, Mr. Editor, yours very truly,

JOHN FAWCETT,

President of the Guy's Hospital Football Club.

66, Wimpole Street, W.
March 22, 1920.

[Copy.]

Buckingham Palace,
March 12th, 1920.

Dear Dr. Drysdale,

I am desired by the King to express to you the pleasure that it afforded to His Majesty to be able to be present at the Final Tie of the Hospitals Competition.

The King was much interested in seeing such a fine and well contested game, and I am to assure you of how pleased His Majesty was by the excellence of all the arrangements and at the loyal and enthusiastic welcome that he received.

Believe me, Yours faithfully,

CROMER.

J. H. Drysdale, Esq., M.D.,
President of the United Hospitals Rugby Football Club,
11, Devonshire Place,
W.1.

Tetany in Children.

[Address to the Physical Society by Mr. W. W. Payne, M.R.C.S., L.R.C.P.

Tetany is a disease which manifests itself clinically by spasms of the larynx, tonic spasms of the hands and feet, and general convulsions. The fact that these three were cardinal symptoms of the same disease, although recognised by Clarke in 1815, Cheyne (1819), Marshall Hall (1841), P. Abercrombie (1880), was not properly understood by the medical world until after Cheadle's paper in the *Lancet* of 1887. The name "tetanic" was given by Corrisart in 1852 to the spasms of the hands and feet, and so strong is the association of the name with this one symptom that many modern writers prefer to call the disease "spasmophilia."

The most striking symptom of tetany, although not the most common, is the tonic muscular spasms. These affect the hand, causing flexion at the metacarpo-phalangeal joints and extension of the phalanges, the thumb is opposed strongly and the wrist flexed, and the hand drawn to the ulnar side; thus the muscles supplied by the ulnar nerve are those mainly involved. The foot goes into the position of talipes equino-varus. Sometimes the spasms affect other muscles, the adductors of the thigh, the anterior trunk muscles or the facial musculature, but this is very uncommon. Except in severe attacks some voluntary movement is possible. There is evidence of pain during the attack, which may last from a few hours to two days. There is sometimes œdema of the hands and feet in the more protracted cases. These spasms are absolutely diagnostic of tetany.

Spasms of the larynx are very common and are often the main symptom. These vary in severity; the larynx may be only partly closed, giving rise to a laboured respiration, each intake of breath being accompanied by a loud crow, or it may be completely closed, when the child becomes pale and cyanotic and makes violent inspiratory efforts. In severe attacks the cyanosis goes on to unconsciousness, and to general convulsions, and sometimes even to death. The attack usually ends with a relaxation of the spasm and the production of a long crow resembling somewhat the whoop of whooping cough. These attacks occur at any time of the day or night, but may be brought about by psychic disturbances, such as temper or fright.

Another common variety is the "holding breath" spells of some children which follow psychic or physical disturbances. In these the diaphragm also seems to be involved, and no attempt to breathe is made at all. Rigidity of the whole body is often

present, which merges into flaccidity with the loss of consciousness which often ensues. General convulsions are a common accompaniment. The child rapidly recovers from an attack, and is in a few minutes apparently as well as ever. Occasionally, however, respiration fails to restart, and all attempts at resuscitation fail.

The convulsions of tetany differ in no way from the usual infantile type, in fact tetany is the most common cause of fits in children between the ages of six months and three years. A typical fit starts with sudden paling of the face, the eyes roll or become fixed, then convulsive twitchings start in some group of muscles and rapidly spread until all the body is involved; they may, however, remain unilateral even when not due to a local cause. Respiration is shallow and the pulse weak and irregular. The attack may last any time from a few moments to half an hour, and leaves the patient in a condition of stupor. Transient paralyses are a not infrequent sequel.

Three signs are associated with tetany:—

1. Chvostek's sign consists of a momentary contraction of the facial muscles on tapping over the facial nerve with a percussion hammer or the finger. The muscles supplied by the part of the nerve stimulated may twitch or perhaps only those of the mouth and alae nasi. This sign if found in children under two years old is practically diagnostic of tetany, and if found in children under four or five years old indicates the probability of the presence of tetany. The sign is present to a mild degree in healthy children over five years, but if a well-marked sign be obtained it is of definite value. Chvostek's sign was first described by Abercrombie in a thesis for his M.D. in 1880.

2. Trousseau's sign. This consists of a reproduction of the typical spasm of the hand muscles when the radial pulse is obliterated for about two minutes by pressure on the upper arm. It is present in only a fifth of the cases of tetany, but is diagnostic.

3. Erb's sign. This is the increased excitability of the nerves to galvanic stimuli. The electrical reaction of the nerves varies with age, and to appreciate this one must know the normal. This has recently been thoroughly worked out by Holmes. He finds that in an infant under one month K.C.C., A.C.C., A.O.C., K.O.C., are all greater than five milliamperes. Between this and two years of age K.C.C. decreases to about 1·7 milliamperes, A.C.C. and A.O.C. to about 3·5 milliamperes. K.O.C. is practically never less than 5 milliamperes, and in the majority of cases A.O.C. is greater than A.C.C. In tetany K.C.C. is diminished and is often less than 1 milliampere, while A.O.C. is less than A.C.C., a reversal of the normal relationship. Lastly, K.O.C. is much less than 5 milliamperes.

Holmes' conclusions as to the value of Erb's sign are that it is positive if:—

1. K.O.C. is less than 5 milliamperes in a child less than five years old.

2. A.O.C. is less than A.C.C. and both are less than 5 milliamperes in an infant under 6 months.

3. A.O.C. is less than A.C.C. and both are less than 2 milliamperes in a child less than five years old.

In children over 5 years electrical testing becomes of less value.

Latent Tetany.

Many cases of children have been found who have had no symptoms of tetany but who have positive Chvostek's and positive Erb's signs. It is customary to regard these children as suffering from latent tetany, and that this is a correct view to take is shown by the fact that if the after-histories of these children are noted they nearly all develop symptoms of tetany. These signs should therefore be regarded as a warning flag and steps taken to prevent the further progress of the disease.

Diagnosis.

The main difficulty in diagnosis is in cases where convulsions are the only symptom. If Trousseau's of Chvostek's signs are present the diagnosis of tetany may be made.

Epilepsy is rare in infants. It can be diagnosed by the history of repeated attacks with an aura or a sudden cry, biting of the tongue, and perfect recovery in a few minutes. It rarely starts with a temperature. An organic brain lesion will produce convulsions; with the exception of acute meningitis there is no elevation of the temperature. There are usually focal signs such as local paralysis or rigidity or strabismus. The fits may be unilateral or always start at the same spot. With meningitis or hæmorrhage the fits recur rapidly, but with a tumour there is a longer interval.

The onset of an acute illness such as pneumonia or scarlet fever may be a convulsive fit. In this case there would be a high temperature and a few hours would clear the diagnosis. These children will sometimes be found to be suffering from latent tetany.

Asphyxia may be the cause of fits, and may occur in the newly born, or complicating pertussis, membranous or spasmodic laryngitis or laryngo spasm.

Lead poisoning is a rare cause of infantile fits. A blue line will be found on the gums if there are any teeth or the stippling of the blood cells might aid in the diagnosis.

In the early weeks of life convulsions are sometimes found with but little to explain them. Sometimes they follow prolonged pressure on the brain during a difficult labour. Slight disorders of the digestive tract sometimes seem sufficient to cause fits,

It should not be forgotten that mental deficiency is a cause of early convulsions.

Phimosis, worms or teething cannot be regarded as a satisfactory explanation for an attack of convulsions, the cause of which should be searched for in other directions. If electrical reactions are done it will be found that most cases of convulsions with no apparent explanation turn out to be tetany.

In looking for the cause of tetany the greater irritability of the central nervous system of an infant has been by some, put to the fore. Tetany is, however, more common in the second six months of childhood than in the first, and also the electrical excitability of the nerves is not greater in infancy; on the contrary, it is less. The instability of the infant's central nervous system rests in the highest centres of control, not in the lower centres, the "reflex" life of the infant being due not to hyper-excitability of the lower centres but lack of inhibition by the upper ones. There does, however, seem to be quite a definite hyper-excitability of the central nervous system, which is hereditary or apparently so.

For a long while tetany was regarded as merely a symptom of rickets, with which it has a very close connection. Practically every case of tetany shows signs of rickets, and in an examination of of 450 Glasgow children who had rickets over 40 per cent. had tetany too, while no case of tetany was found amongst 200 non-rachitic children examined at the same time. However, there are some cases of tetany without rickets, and also there seems no connection between the severity of the rickets and the liability to contract tetany. Many severe cases of rickets do not get tetany, while many light cases do get tetany. Since however they both have the same seasonal incidence (being more prevalent in winter) and since they undoubtedly are closely connected it is evident that those causes which produce rickets probably have a hand in producing tetany too.

Briefly the causes of rickets may be set out as under:—

1. It is the result of persistent breaking of the elementary rules of hygiene, insufficient air and exercise ,lack of nourishing food, lack of parental care, and too large families.

2. It is due to a defect in diet, a necessary vitamine is lacking from or deficient in the diet (this vitamine is known as Fat Soluble A).

3. It is the result of persistant infection in an individual whose resistance is lowered by either factor 1 or 2 or both.

4. It is due to errors in calcium metabolism.

Owing perhaps to the success which it has met, investigations have nearly all been upon this last factor, calcium metabolism.

Another factor here, however, appears. It was noticed that men and animals who had had their thyroids removed suffered from spasmodic affections which in every way resembled tetany even to increased electrical excitability. As these were so different from the recognised lesions caused by the thyroid, attention was attracted to the possible explanation, and the para-thyroid glands were discovered. After a stormy fight for a separate existence it has now been fairly conclusively shown that these are independent bodies which arise from the third and fourth branchial clefts in conjunction with the thymus, and apparently it is through their removal that tetany in thyroidectomy occurs. The majority of experimental work has been performed on parathyroidectomised animals, the remainder being on the genus homo.

The seat of the hyper-excitability has been diligently sought for. If all the nerves to a limb be severed the convulsions cease in it, and the nerve loses its hyper-excitability; if not all the nerves be severed the severed nerve retains its hyper-excitability. This only shows that it is not the muscles which are the cause.

If an animal whose cord is severed in the mid-dorsal region has tetany the flaccid paralysed hind limbs go into a modified convulsion. These convulsions are so distinctly different from the normal ones that it cannot be denied that the higher centres have a hand also in the matter. If convulsions occur in a dog whose cortex has been removed on one side no difference between the two sides is noticed until the end of the attack, when the paralysed side is distinctly more flaccid than would be expected. Lastly, if the blood of a tetanic dog be transfused through the limb of a normal dog that limb will go into convulsions and will exhibit the characteristic electrical reactions and conversely if normal blood be transfused through the limb of a tetanic dog that limb will not go into convulsions when the rest of the dog does, until its normal circulation is restored. This points to the source of the irritation being in the peripheral nerves. Putting all these together, it would seem that every synapse in the motor-sensory system has been made more permeable to stimuli.

(To be continued.)

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

University of London Officers' Training Corps War Memorial Fund.

We publish below an appeal on behalf of the War Memorial Fund of the University of London Officers Training Corps, and append a sketching of the Memorial Hall and a plan of the Standing Camp which the Executive Committee propose to erect out of funds subscribed.

THE APPEAL.

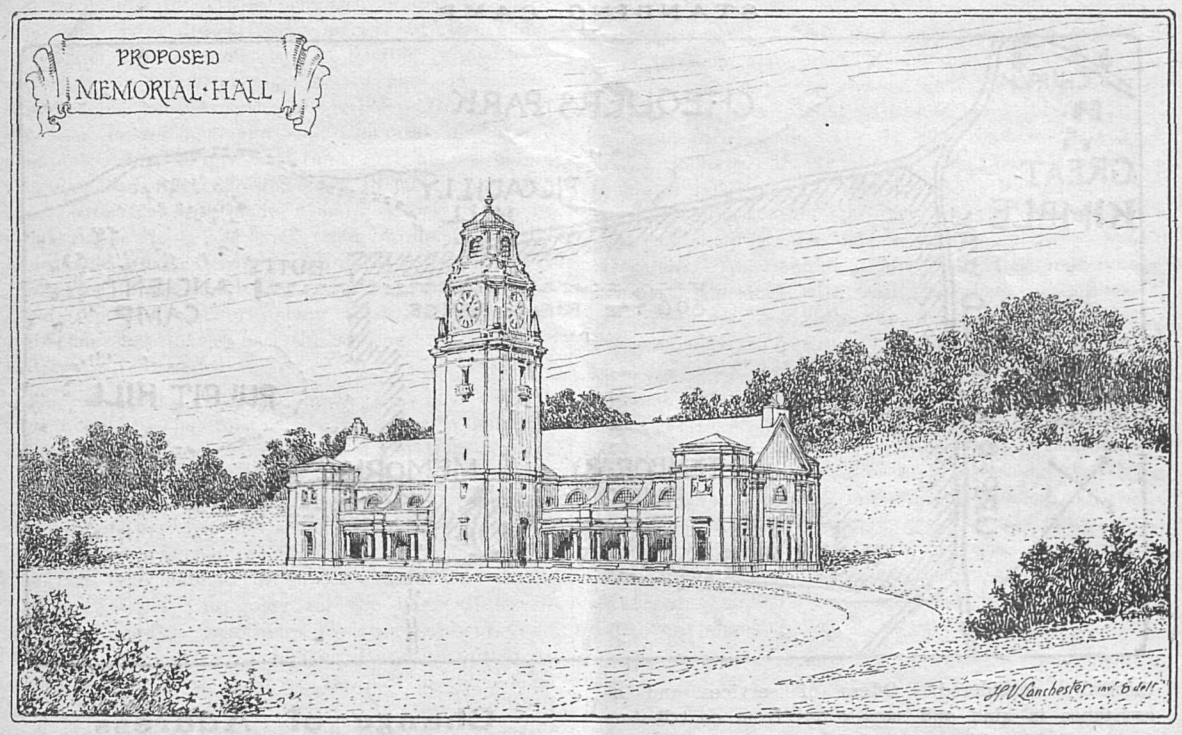
On behalf of the Appeal Committee, we desire to invite contributions to a Fund for establishing a Memorial to the past members of the University of London Officers Training Corps who have fallen in the War and to commemorate the War Service of past and present members of the Contingent.

The Roll of War Service of the University of London O.T.C. is at present being compiled and will be published as early as possible in 1920. The following is a summary of the War Service to be recorded in detail in the Roll:—

The number of past and present officers and cadets who have served in the War as officers is 4,197. The first commissions granted were 3,787 in the Army, 385 in the Navy, and 25 in the Air Force; but it is to be understood that a number of officers transferred from one branch to another, *e.g.*, from the Army to the Royal Air Force. These officers served on every front in the War and assisted in the defence of London, one of them bringing down in flames a Zeppelin near the city and later a Gotha aeroplane.

Of these officers 657 are known to have fallen in the War but it is feared that this number may be increased when full information is received.

The number of distinctions gained in the War is 1,650, including V.C., 5; D.S.O. and Bars, 54; D.S.C., 8; M.C. and Bars, 588; D.F.C. and Bars, 10; A.F.C., 9; Mentions in Despatches, 707; *Croix de Guerre* (French) 27, (Belgian) 15; Silver Medal for Military Valour (Italian), 5; Distinguished Service Medal (United States), 2.



In addition, a number of former cadets served in the ranks. As it has not been possible to collect full information in regard to the War Service of these cadets, statistics cannot be given. The names of any such who are known to have fallen in the War will be included in any list of the fallen which may be prepared in connection with the War Memorial.

The Appeal Committee consider that any scheme for a War Memorial in connection with the University of London O.T.C. should include a Memorial in London and therefore propose to allocate to such Memorial a suitable sum from the Fund which may be collected as the result of this Appeal. Details of this Memorial are not at present settled but it is

proposed that the Memorial should be of a purely commemorative character.

As supplementing the Memorial in London, it is suggested that a permanent Hall might be provided for the Standing Camp of the Contingent at Great Kimble, near Princes Risborough, Buckinghamshire, particulars of which are appended.

It is proposed to dedicate a personal memorial at the Standing Camp to Lt.-Col. Arthur Egerton, Coldstream Guards, first Adjutant of the University of London O.T.C. (1909-13), who fell in action near Loos on September 29th, 1915.

Proposals for other special memorials at the Standing Camp to individuals or groups will be sympathetically considered. Offers of services and of assistance in kind and suggestions from contributors to the Fund will receive full consideration.

The amount which it is hoped to raise for the complete scheme is £30,000. If desired, contributions may be allocated either to the Memorial in London or to the Memorial at the Standing Camp. Any profit on the publication of the Roll of War Service will be devoted to the War Memorial Fund.

This Appeal, which is issued with the sanction of the Senate of the University, is addressed to all past and present officers and cadets of the University of London O.T.C. and their friends, to students, graduates, teachers, and officers of the University, to its Colleges, Schools and Institutions, to all who have been associated with members of the Contingent in their work for the War, and to others who may desire to assist in establishing this Memorial and in improving the facilities for military training within the University of London.

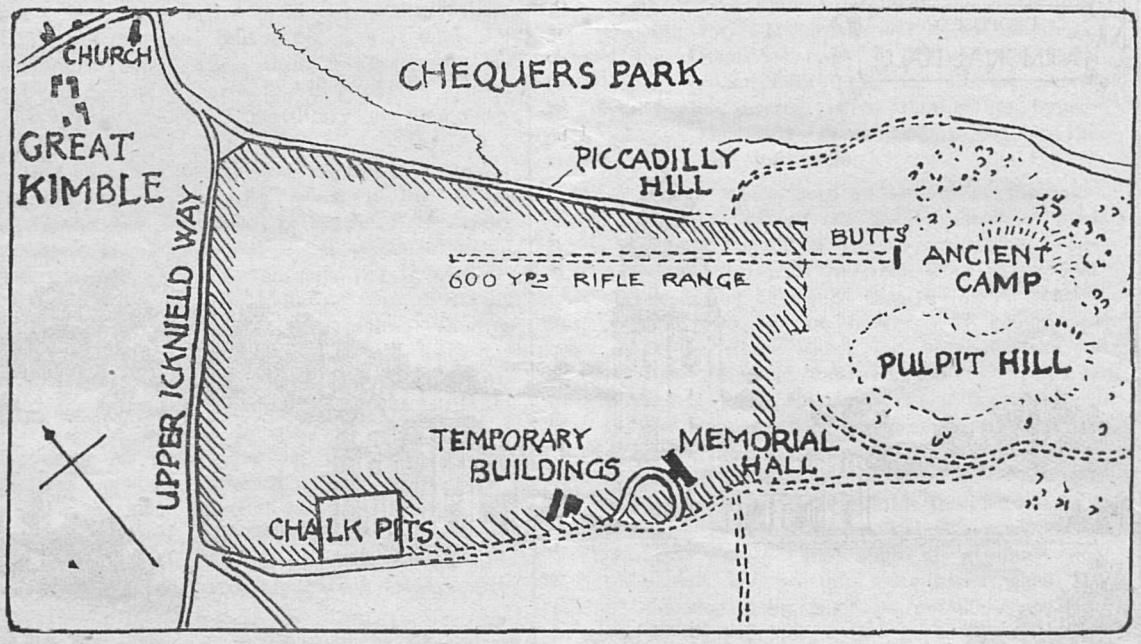
Contributions to the Fund should be remitted to the Hon. Treasurer at 46, Russell Square, London, W.C.1.

ROSEBERY,
President.

EDWARD H. BUSK,
Vice-President.

46, Russell Square,
London, W.C.1.
March, 1920.

STANDING CAMP.



Change of Address.

W. E. Willis, B.A., M.B., B.C., The Mount, East Grinstead, Sussex.

H. Rowse-Bastard, M.R.C.S., L.R.C.P., Fair Park, Bow, Devon.

Russell John Reynolds, M.B., B.S., 140, Harley Street, W. (Tel. Mayfair 2720).

F. D. Saner, B.A., M.B., B.C., 81, Hamilton Terrace, N.W. (Tel. Pad. 4690) and 32, Devonshire Place, W.1. (Tel. Mayfair 4043).

Temp. Surg. Lieut. Maurice Pearson, R.N., from H.M.S. "Renown" to Rowardennan, Bovey, Devon.

Football.

GUY'S v. BLACKHEATH.

After one or two unsuccessful attempts to bring this fixture off, the match was at length played at Blackheath on Wednesday, March 24th. We were at practically full strength, except for J. A. Krige, who had influenza. Hence P. J. Krige went centre with Graham Davies, Reitz and Daneel filling the wing positions. Blackheath had the best of the first half; their forwards got the ball out smartly to the men behind them, but the Hospital tackling was hard and healthy. Both Lowe and Harris were well watched. When things began to go well we had hard luck in getting penalised in a rotten position and at a disheartening period of the game. Coverdale had no difficulty in landing a goal. It was rather a severe penalty for a crime which many would have passed over altogether. However, it was our misfortune, and our men did not worry about it. Just before half-time, and almost before the team had fully digested their ill-luck, Spriggs, a Blackheath forward, made a mark a long way out. Cumberledge took the kick, and dropped a really remarkable goal. Giving the English full-back every credit for his splendid kick, one does not think he could repeat the effort many times in succession. Half-time was taken, and the scoring, as was ultimately proved, ended.

The Hospital had very much the best of the second half. The forwards gave a really splendid exhibition. Doherty, Marais, Neser and Duncan were very good indeed, but our backs were not convincing. There was a good deal of handing the ball to one another but no snap in the passing, and surely there was too much of that oblique kicking. The last two matches or so have found our backs lacking "ginger" in going for the line. However, there is always something to grouse about, and probably disappointment at the Hospital failing to win after having so much of the ball in the second half stimulates adverse criticism. It was jolly hard luck to lose with our line still uncrossed. Scores: Blackheath, 1 penalty, 1 mark goal, 6 points; Guy's, nil. Guy's team:—

W. Olivier, P. J. Krige, H. Graham Davies, F. W. Reitz A. Daneel, F. Bekker, J. Van Schalkwijk, W. D. Doherty, G. E. Kidman, A. H. Shellswell, A. Marais, H. Van Zijl, R. R. F. Duncan, E. E. Neser, and A. Pauw.

Olivier played a very good game indeed. His worth is being generally recognised, though rather late in the season. Bekker was not quite up to his usual form, but all the same better than Horan of Blackheath. Graham Davies was the best of the three-quarters, but all defended splendidly; their plan of attack has already been referred to.

GUY'S v. OLD BLUES.

It was a pity that this match at Ravensbourne should have occurred on the Saturday after both Hospital XV.'s had had strenuous mid-week matches, also that the 'Varsity Boat Race and Sports, as well as London v. Leicester game, should be all on the same day (March 27th).

Yet 14 good men turned up at Ravensbourne to uphold the honour of the Hospital. Van Schalkwijk was playing for London at Leicester. I particularly mention him, because if my memory be correct this is the only match or practice game that the stand-off half has missed; a rare record of enthusiasm and pluck. Sometimes after a hard mid-week match a rest would have been no doubt welcome, but Van Schalkwijk has stuck bravely to the team throughout. The 14 who went to Ravensbourne included H. G. Close and Chambers, who do not usually play in the first XV., but they and D. J. O'Meara, the secretary of the Association Club, gallantly turned out to lend a hand; it was particularly sporting of O'Meara. After half-time Meacock, who had with real grit done his utmost to stay on the field after his knee had given way, was compelled to retire. The first half was played with the wind behind us, and right well did the depleted side play, but the forwards had a very hard time. It is remarkable how they stuck to their opponents so well. Shellswell, Neser and Watson were very good, and so was Sprong at half. As our forwards were unable, not unnaturally, to get the ball, the three-quarters had few chances. Though Williams was almost in once, Crisp was steadiness itself at back, and only one goal was registered against us from a try got by Mills before ends were changed.

Neser landed a penalty for us after resuming, and Purver and Pennington put on a couple of tries for the Blues; Lewis converting once with a fine kick. Van Hearden got away very neatly once or twice. On one occasion he could have run it out, but looked about too long for someone to pass to. All the time Sprong was hard at it; twice he and Van Nickert were stopped inches out. Daneel did most in defence. Neser at stand-off (Meacock having gone off) was quite good. Just before the end Daneel got right away from mid field and ran clean in to the posts, Neser missing a sitter. The game ended Old Blues, 2 goals, 1 try, 13; Guys, 1 penalty, 1 try, 6. Guy's team:—

E. J. Crisp, H. K. Williams, A. Daneel, H. Van Hearden, J. Van Nickert, S. P. Meacock, E. L. Sprong, A. H. Shellswell, E. E. Neser, L. K.

Watson, R. R. F. Duncan, H. G. Close, D. J. O'Meara, and Chambers.

This was our last match, and it is a pity to have lost it, but this was not the fault of the players. They did wonderfully well, and are to be congratulated on keeping so close to a really good team. The Old Blues have done well in their recent matches, and but for the splendid tackling of our defence, aided whenever possible by all the forwards, a big score would have been run up against the Hospital.

Reviews, etc.

Medieval Medicine. By Professor J. J. Walsh. (Messrs. A. & C. Black) 12mo., pp. 221; price 7s. 6d.

Given a knowledge of his subject and a style above pidgeon English, it would be difficult for any man to make uninteresting so engrossing a study as the history of medicine. Professor J. J. Walsh's book on medieval medicine, while giving a birds eye view of progress in the art of healing during the thousand years before the fall of Constantinople, contrives to be a most fascinating volume. Constantly throughout the book the reader is overtaken by a recurring sense of astonishment at the genius of these forgotten pioneers, who with their crude instruments succeeded in making surgery a highly developed art, and who, hampered by religious and lay prejudices endeavoured to place medicine on a rational and humanitarian basis. It is probably the details given of medical practice, centuries ago, which makes "Medieval Medicine" especially interesting to the modern reader. Thus we read that Alexander of Tralles recommended an abundance of milk and a hearty nutritious diet, together with a visit to the seaside or a long sea voyage to his phthisical patients, and that Pietro d'Argelata was in the habit of inserting drainage tubes into wounds. As Dr. Walsh points out, much of the progress made in the so-called Dark Ages was lost in the centuries that followed. Thus anæsthesia by means of opium inhalations from a sponge was frequently used for operations in the 14th Century, and extension apparatus was employed for the straightening of contracted joints. Then, too, the medical schools of the Middle Ages held their doors open to women-students, and it was not until the Renascence, with its new ideas and new prejudices, that the medical schools became closed to women (in response to public opinion) for five centuries. One suggestion only we have to make. We should like to have received a more intimate knowledge of these medieval physicians and surgeons and a more detailed picture of the old-time universities, and we think if one or two extra chapters on these subjects had been added, the extra effort of the author in writing them would not have been wasted, nor the time of the reader, in reading them, ill-spent.

Notices.

It is requested that borrowers from the Wills' Library will return all books of reference to the Librarian as soon as possible.

GEO. A. R. WINSTON,
Librarian.

The Dean requests that the Teachers and Students of Guy's Hospital will forward to the Wills' Librarian a list of their publications for the Session 1918-1919.

A Post-Graduate Course on Spa-Treatment is to be held at Bath this year from June 7th to 19th.

Accommodation for members of the Course can be arranged if they will apply to the Secretary stating their requirements. In addition the Bath Chamber of Commerce hopes to arrange for motor charabanc tours to places of interest during the spare time of the Course.

All information with regard to the Syllabus of this Course, to accommodation, and to any other matters may be obtained from

John Hatton, Esq.,
The Pump Room,
Bath.

Honours.

Croix de Guerre.

Temp. Capt. H. L. Messenger, M.C., for services in Macedonia.

Births.

DAVIES-COLLEY.—On March 27th, at 10, Devonshire Place, W., the wife of R. Davies-Colley, C.M.G., M.Ch., of a son.

MESSENGER.—On February 26th, at Rosslyn Hill, Hampstead, the wife of Capt. H. L. Messenger, M.C., a son.

REINHOLD.—On March 6th, at the Anglo American Hospital, Cairo, the wife of Major C. H. Reinhold, M.C., I.M.S., a son.

REYNELL.—On March 24th, at 26, Nottingham Place, W.1., the wife of W. R. Reynell, M.D., M.R.C.P., a son.

TANNER.—On March 17th, at 48, Philbeach Gardens, Kensington, the wife of W. E. Tanner, M.S., F.R.C.S., a daughter.

Death.

KEY.—On Saturday, March 20th, at 65, Elm Grove, Southsea, in his 80th year, Benjamin Harrison Key, Cmdr., R.N., youngest son of the late Charles Aston Key, F.R.S., Senior Surgeon of Guy's Hospital.

Ed.—M. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIV., No. 829.] APRIL 17, 1920. [SIXPENCE.

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Passim.

WE hear that Lawn Bank, Hampstead, the house in which John Keats lived for many years has been put up for sale in the property market as an eligible building site. A committee, however, has been appointed with the object of maintaining the house intact and employing it as a museum, wherein to house the Dilke Collection of Keats' Relics and other objects of associated interest. To preserve Lawn Bank for the nation a sum of £10,000 is required, and the public are invited to forward donations to the Hon. Treas. of the Keats' Memorial House Fund, Town Hall, Haverstock Hill, N.W.

WE mention the Keats' Memorial Fund in the GAZETTE partly because we think that those of our readers who are at all interested in literature are bound to approve of the scheme on purely general grounds, but more especially because of the fact that the poet himself was an old Guy's student. He entered the Hospital in 1815 (living at that time in St. Thomas's Street), and in 1816 he became a dresser to Mr. Lucas, and later in the same year he qualified.

If sufficient money is not collected by the Committee, Keats' House will be pulled down, and on its site, no doubt, a number of small, red-brick, and highly eligible dwelling houses will be erected; if, on the other hand, the £10,000 is forthcoming, an historic house and a collection of great literary interest will be preserved for the nation as a whole and for lovers of poetry in particular. We lay the two alternatives before our readers, and hope that those of them who think it worth while to retain this link with Guy's of a century ago, will send a subscription to the Treasurer of the Fund—Sir Sidney Colvin.

IN the last issue of the GAZETTE we had occasion to comment on the necessity for a medical campaign against the anti-vivisection and anti-vaccination agitators in this country. Carried away by our own enthusiasm we inadvertently made the following statement: "Largely owing to the activities of Stephen Paget and his disciples a large proportion of the population . . . is unprotected by vaccination." Of course, the individual we had in mind, when we wrote this sentence, was Stephen Coleridge, the big bassoon in the Anti-vaccination Band. Mr. Paget, as everyone knows, is the Secretary of the Research Defence Society, and as such has rendered sterling service to the whole

medical profession by his earnest and sustained efforts against the insidious propaganda of the "Abolitionists."

As we announced recently, the Football teams have already won four cups, and the close of the football season is very fittingly marked by the acquisition of still another one —the London University Association Football Cup.

Meanwhile we look forward with great interest to the Cricket Season and hope that the support given to the Guy's teams will be very much better than it was in 1919.

Dr. Ireland, Surgeon General to the United States, comments on the low standard of physical health attained by the average civilian and considers that the best remedy for this state of affairs would be the institution of compulsory military training for all youths on their attaining the age of nineteen.

This suggestion reminds us of the method of roasting pork first elaborated by Bo-Bo, "whose father's house was observed to be in flames every time the old sow farrowed."

In the first place the conscripted man on leaving the army and returning to his old home and employment, would soon relapse into the original state of physical inefficiency induced by the environment of his early youth; it is perfectly useless to take a man into the army for two or three years with the object of improving his health if at the end of that time the State is going to send him back to his two-roomed flat in Brighton Buildings (down in the Old Kent Road).

In the second place, the female portion of the population would, of course, not be conscripted, and would, therefore, not be benefitted at all by these new military arrangements of Dr. Ireland.

After all, at the root of a nation's ill-health are bad social and industrial conditions, and it is against these factors that the energies of Governments must be directed if they wish to maintain a high standard of national well-being.

We were glad to see from the new list of Medical School Appointments that there will be an ample supply of ward clerks for the four surgical units during the next three months. The Surgical dresser will, on the one hand, be relieved of the burden of writing reports of his cases and of a hundred and one other little duties which, combined, made his appointment one of the most arduous in the hospital, while the student who has just passed his Second Examination will have an opportunity of learning the procedure observed in the theatres and wards, without the necessity of taking a very active part in the work himself. He will also have, in addition, time to read, and to go round the wards with the Registrar, and, in short, he will have opportunities of learning theoretical surgery which were denied him under pre-existing arrangements.

We would draw the attention of our readers to the announcement, in this issue of the Gazette, of the forthcoming concert of the Guy's Hospital Musical Society. This is the first concert to be given since the war, and we hope it will be well supported by members of the hospital and their friends. We hear that the services of Mr. Clive Carey have been secured for the concert. All those who remember him and his singing in the concerts before the war will be glad to hear that he is still taking an

active interest in the Society for which he worked so hard for many years, and will look forward to his re-appearance on the platform, where he was once such a popular figure.

It was with great pleasure that we read of the marriage of the Superintendent to Miss Margaret Wallace, on April 10th. We take this opportunity of offering our congratulations to both Mr. and Mrs. Eason, who may be sure that they possess the very best wishes of everyone who is in any way connected with Guy's Hospital.

At the last General Court of the Hospital, Dr. J. A. Ryle and Mr. E. G. Slesinger were appointed to the posts of Fifth Assistant Physician and Fifth Assistant Surgeon respectively. Both Dr. Ryle and Mr. Slesinger are men of wide experience and originality, and their appointment will help to maintain the traditions of the long line of distinguished physicians and surgeons who have graced the Guy's Staff during the past and present century.

Change of Address.

Allen C. Hancock, M.C., M.R.C.S., L.R.C.P., Cane Hill Mental Hospital, Coulsdon (Tel. 5 Purley).

B. Gore Reynolds, Colville House, Ealing, W.

F. D. Saner, B.A., M.B., B.C., F.R.C.S., 81, Hamilton Terrace, N.W. (Tel. Pad. 4690), and 32, Devonshire Place, W.1. (Tel. Mayfair 4043).

W. Tyson, M.A., M.D., B.C., F.R.C.S., North Cottage, Lowestoft.

G. Wilshere, 316, Lordship Lane, E. Dulwich, S.E.22 (Tel. Sydenham 1595).

C. P. Symonds, M.D., c/o Baltimore Trust Co., Baltimore, Maryland, U.S.A.

J. E. Davies, Melrose, Bishops Road, Whitechurch, Cardiff.

J. York Moore, Chapel Road, Duxford, Cambs.

D. H. A. Galbraith, M.C., M.R.C.S., F.R.C.P., Poplar and Stepney Sick Asylum, Bromley-by-Bow, E.3.

S. Vidot, c/o Quarantine Office, Port Tewfik, Suez, Egypt.

A Case of Urticaria of Eight Years' Duration Associated with Hyperthyroidism.

By H. W. BARBER, M.D.

The case to be described was under my care for a period of nearly four months in Guy's Hospital. It should prove of interest both to the dermatologist and to the general physician, since it appears to illustrate the importance of focal bacterial infections in the productions of symptoms that at first sight may seem very difficult to account for.

The patient, a girl of 21 years, school teacher, was sent to my Out-Patients at Guy's Hospital by her medical attendant on account of a constantly recurring urticarial rash of eight years' standing. Her history was as follows: At ten years of age she had influenza, from which she completely recovered, and she remained in perfect health until the age of twelve and a half, at which time she noticed that her neck was becoming swollen; nine months later her periods began, and have since remained quite regular.

She found, however, that the gymnastic exercises at school caused her distress and undue fatigue, and she was examined by the Medical Officer who discovered that she had an enlarged thyroid; she was, therefore, advised to take walking exercise only, and her neck subsequently decreased in size, and she felt better.

Shortly afterwards, however, at the end of an unusually brisk walk, she noticed two "white" itching spots on the upper part of her left arm, which she thought were insect bites. But the same type of rash began to appear with greater severity on both arms, and on the neck and face, whenever she took a walk, and later it came to involve almost her whole body. The itching and burning were intense, and the outbreaks became more frequent. Her doctor treated her for "nettle rash," but without success.

At the age of eighteen and a half the severity of the attacks increased still further, large urticarial plaques appearing on the least excitement or exertion; moreover, the mucous membranes became affected, and the lips, tongue and throat were often swollen, so that difficulty in swallowing and in speaking was experienced. After the attacks the patient felt weak and

dazed. She was given various medicines, but none seemed to have any influence whatever.

Later, too, she found that excitement, exertion, or excessive mental work would bring on attacks of palpitation, and she suffered much from insomnia. Finally, in May and June of last year she became so languid, and lost weight so quickly (14 lbs. in six weeks), in spite of taking as much rest as possible, that she was sent to hospital for further advice. Her mother had observed recently that her eyes were becoming more prominent.

When I first saw the patient the rash was not present, but it was evident both from her own and her doctor's story that it was of an erythematous and urticarial nature. I observed that the thyroid was very considerably enlarged, there was slight tremor of the fingers, and the pulse rate was 140. There was no evident exophthalmos, in spite of the mother's statement already referred to. I came to the conclusion that we were probably dealing with a mild case of Grave's disease, in which condition erythematous and urticarial rashes are frequently seen. At my suggestion the patient was admitted to hospital on June 18th so that a thorough examination could be made.

General condition. — She was a fresh-complexioned girl of medium stature, well covered with subcutaneous fat; weight 8st. 7lbs. 12oz. Alternate flushing and pallor of the face during conversation was at times remarked, suggesting vasomotor instability. Her appearance certainly did not indicate intestinal toxæmia. Examination of her blood showed a slight degree of anæmia of the chlorotic type. The *thyroid gland* was uniformly enlarged, the enlargement being very evident even at a considerable distance. The *pulse* was rapid (140), of low tension, and apparently perfectly regular. There was very obvious carotid pulsation in the neck. *Heart.*—Both sounds abnormally loud, as in Grave's disease; no enlargement to percussion, and no bruits audible; the patient complained of palpitation even in bed. *Lungs* apparently normal. *Alimentary Canal.*—Appetite good; no complaint of indigestion or constipation; teeth ,on the whole, in good condition, and no external evidence of pyorrhœa alveolaris. X-ray examination showed the stomach and duodenum to be normal. There was slight delay in the lower end of the ileum, but after twenty-four hours the greater part of the barium meal lay in the descending colon and rectum. Bacteriological examination of the fæces gave a growth of bacillus coli only.

Urine.—Acid. No albumen or sugar. A slight trace of indican.

Skin.—Moist and warm. The rash, when present, was partly erythematous, partly urticarial. At times it was generalised over the face, trunk and limbs, at times confined to the face and arms. It appeared even when she was lying in bed, usually on waking in the morning, but was always most marked when she was allowed to get up and move about the ward. Sometimes the appearance of the rash was accompanied by swelling of the eyelids and tongue, and nearly always by palpitation of the heart and a disagreeable sensation of heat and shortness of breath.

Progress.—It was decided to keep the patient completely at rest in bed. Laxatives were given, to ensure daily evacuation of the bowels, and a mixture containing calcium lactate and Fowler's solution. No evidence could be obtained that alteration of diet had the slightest influence on the appearance of the rash; restriction to milk alone, a protein free diet, and one containing a minimum of carbohydrate were all tried in succession for periods of several days without any effect.

At the end of four weeks, although the rash did not appear so frequently or with such severity, there was really very little improvement in the patient's condition. The *pulse rate*, in spite of rest in bed, varied between 140 and 110, though during sleep it sometimes fell to 100. During this period a gain of five pounds in weight was recorded. The thyroid had diminished slightly in size.

I was, therefore, forced to the conclusion that the tachycardia, the thyroid enlargement, and the eruption must be due to chronic intoxication from some focus of infection. The result of the X-ray examination, the investigation of the fæces, and the negative influence of change of diet made it very unlikely that she was suffering from intestinal toxæmia, and I was assured by the dental surgeon that there was practically no oral sepsis.

One day I was struck by the appearance of the tonsils, to which my attention had not been previously directed, and I asked Mr. T. B. Layton to report upon them. His report was as follows: "The ears are normal. There

is no evidence of sinus disease. There is reddening of the anterior fauces, the tonsils are deeply embedded, have deep crypts, in which are masses of white concretion. At points on the surface, the tonsils are redder than normal. I think these may be a cause of septic infection, and that their removal is well worth doing."

Accordingly, on July 24th, Mr. Layton removed the tonsils under a local anæsthetic, and bacterial cultures were made from the tonsillar crypts by Dr. F. A. Knott; these gave a growth of a typical streptococcus pyogenes longus and of a staphylococcus aureus, the former predominating. A mixed autogenous vaccine was prepared from the cultures.

For twenty-four hours following the operation the pulse rate rose, and a rather acute attack of urticaria developed the next morning. During the next five days the pulse rate remained at a lower level than previously (94—112); on the sixth day (30/7/19) the first dose of vaccine was given ($2\frac{1}{2}$ millions streptococci, staphylococci proportionately). This was followed the same evening by a rise of pulse rate (124), a slight erythematous rash, but no rise of temperature.

4/8/19.—5 millions given. No obvious reaction.

8/8/19.—$7\frac{1}{2}$ millions given. Slight rise of temperature on the evening of the following day; some headache; rather severe rash.

11/8/19.—10 millions given. Temperature rose to 99·8° the evening of 12/8/19. Pulse rate rose from 100 to 120. Some malaise, and generalised urticarial rash.

The patient was now allowed to get up and go about as she pleased. In spite of this the pulse rate remained between 100 and 110, and only very slight and transient outbreaks of the rash occurred.

16/8/19.—10 millions given. Temperature rose to 100° the next day, and to 99° the evening of the following day. The patient complained of headache, and a feeling of irritation in her skin; only a slight rash appeared. She was kept in bed during these two days.

22/8/19.—10 millions given. This was followed by no reaction. During the next three days the pulse rate fell to 80—110. Little or no rash during this period. The thyroid gland was now very noticeably diminished in size.

25/8/19.—15 millions given. On the evening of 26/8/19 the temperature rose to 103° and the pulse rate to 140. The patient felt ill and there was evidently severe cutaneous reaction. The temperature gradually fell during the 27th, the pulse rate remaining between 130 and 120.

2/9/19.—15 millions again given. No reaction.

8/9/19.—20 millions given. No reaction.

During the next four weeks doses of 25, 35, 50 and 100 millions were given without any obvious reaction. The patient had no rash whatever during this period, the thyroid became reduced almost to normal size, and she felt better than for years past. The pulse rate tended to remain at between 100-110. She was discharged on October 11th apparently perfectly well. During her stay in hospital she gained over a stone in weight.

Comments on the Case.

The main symptoms presented by my patient were (1) enlargement of the thyroid gland, (2) tachycardia, (3) palpitation, (4) loss of weight, and (5) an erythematous and urticarial rash. As might be expected, since her symptoms, particularly the rash, had always been aggravated by bodily and mental activity, rest in bed produced some amelioration of her condition, but it will be observed that it had very little influence on her pulse rate, and it diminished the severity rather than the frequency of the outbreaks of urticaria.

To draw unjustifiable conclusions is only too easy when patients are removed from their home surroundings to hospital, since so many factors may be brought into play by the change involved, but it is difficult to avoid the conclusion that the symptoms in this case were directly or indirectly caused by chronic toxæmia from infected tonsils, the toxin being almost certainly derived from a streptococcus.

The chief points in favour of this view are as follows: (1) Following the removal of the tonsils, after an initial rise, the pulse rate fell very considerably; (2) The earlier doses of autogenous vaccine, though small, were followed by very definite reactions, as evidenced by rise of temperature, in one instance to as high as 103°, and of pulse rate, and apparently by an aggravation of her rash; (3) After the vaccine treament had been instituted, the patient found that she could go about the wards

and hospital grounds as she pleased without developing any of her former unpleasant symptoms, whereas mere rest in bed in no way lessened her susceptibility to exertion; (4) With the higher doses of vaccine no reactions were obtained, and the patient remained without any rash during this period; (5) Although her thyroid diminished in size to some extent during her first four weeks in hospital, the diminution was very much more striking after the removal of the tonsils and the institution of the vaccine treatment.

The rôle played by focal infections in certain diseases, such as rheumatoid arthritis and some forms of anæmia, is well recognised by English physicians, but it is chiefly among American dermatologists that their association with certain skin diseases has been considered (*vide* "Focal Infection in the Etiology of Skin Disease," by E. D. Chipman, and the subsequent discussion, Journ. Cut. Dis., October 17th), partly, perhaps, owing to the work of Rosenow. At the same time, Darier, in the Memento Therapeutic of his incomparable "Précis de Dermatologie," insists on the connection between oral sepsis and many skin diseases such as rosacea, eczema, pruritus, and alopecia areata.

I am of the opinion that chronic infection of the tonsils is at least as important an etiological factor in the production of certain skin diseases as is oral sepsis, and it is far more likely to be overlooked.

N.B.—Three other cases of urticaria, due apparently to absorption of streptococcal toxin, have come under my care since the above article was written; in two of them, large swellings of the character of angeioneurotic œdema also occurred. In one the focus of infection was the tonsils, and there were symptoms of hyperthyroidism; removal of the tonsils, followed by injections of autogenous streptococcal vaccine, resulted not only in the disappearance of the urticaria, but also in great improvement of the patient's general health. In the two other cases the teeth were the source of infection. The first patient had had urticaria and œdematous swellings for two years. Extraction of the teeth and vaccine treatment have very greatly improved his condition, and he now has only slight urticaria from time to time, which is doubtless due to intestinal streptococcal infection. In the second case improvement has been much more rapid. When he first came under observation, his life was a misery, for he was practically never free from urticaria, and at night large œdematous swellings would occur in various parts of the body and on his lips and tongue. He has only had vaccine treatment for a few weeks, and he is already nearly well.

The Dental Department.

On and after Monday, May 3rd, 1920, the number of tickets to be allotted to patients requiring extractions under gas will be as follows:—

	Morning.	Afternoon.
Monday	25	25
Tuesday	25	25
Wednesday	25	
Thursday	25	25
Friday	25	25
Saturday	25	

If necessary, all the above tickets will be issued in advance. Extra or Special tickets to the number of 5 for each session may be issued on the day for which they are to be used, but for no session will the total number of tickets issued exceed 30.

The morning sessions will start at 9 a.m. as hitherto, and the afternoon sessions at 2 p.m.

The issue of anæsthetic tickets for the Children's Department is independent of the above, and, as at present, consists of 10 on Wednesday morning and 10 on Saturday morning. These cases will be seen on these mornings directly after the adult cases have been finished.

Extractions under a local anæsthetic or without an anæsthetic will take place as usual in the mornings at 9 a.m.

Guy's '89 Club.

The 24th Annual Dinner—postponed owing to the railway strike in October last—will take place at Jules' Hotel and Restaurant on Wednesday, 12th May, at 7.30 p.m. The following members have already intimated their intention to be present:—W. Sampson Handley (President), C. D. Edwards, C. H. Fagge, R. H. Fagge, R. H. Hayes, W. J. Henson, A. C. Hovenden, B. G. Reynolds, A. Scott-Turner, F. J. Steward, H. M. Stewart. The Secretary, H. J. Spon, who has posted cards of invitation, will be glad to have replies to 61, Harley Street, W.1.

Tetany in Children.

[Address to the Physical Society by Mr. W. W. PAYNE M.R.C.S., L.R.C.P.

(*Continued.*)

Returning to calcium metabolism, this aspect of the matter has received much attention; at first in man calcium metabolism experiments were undertaken to see if there was any difference between the normal calcium retention and that of a tetanic individual. The figures obtained were found to be unreliable owing to the too short periods taken and the large variations the normal underwent. However, on the whole they pointed to a marked lessening in calcium retention in tetany and a lesser one in rickets. MacCallum has shown, however, that there is a lessened amount of calcium in the blood in the parathyroidectomised animal, and that when this diminution falls below 50 per cent. tetany occurs. This can be checked by giving calcium salts; also blood from which calcium had been removed by dialysis caused tetany when transfused through a limb of a dog.

More recently Howland and Marriott have examined large numbers of normal children of all ages—healthy, with rickets, and with tetany. They found that the normal amount of calcium in 100 c.c. of blood was very constant—between 10 and 11 mg. In rickets it averaged 9·4 mg., no case being less than 8·3 mg. In tetany it averages 5·6 mg., the range being from 3·5 to 7·3 mg. These figures agree very closely with MacCallum. In several cases of convulsions not due to tetany the calcium was found to be within the normal limits.

A similar set of experiments was done to determine the magnesium content of the blood. This was found not to vary to any extent in any of the cases.

They also found that substances which precipitated calcium in the blood caused tetany. Thus the injection of sodii phosph. reduced the calcium in the blood and caused tetany. In view of the fact that there is a phosphate retention in nephritis, they examined the phosphate content of several cases of tetany, but found no increase. They also found that giving large doses of alkali, e.g., Sodii Bicarb., caused tetany, but no "alkalosis" was found in any case of tetany examined.

In view of these findings it is of interest to note the effect of calcium on muscle and nerve. Calcium is necessary for the proper working of the heart muscle, to which it gives an increased tonus. Also *without* calcium there is no transmission of the excitatory states from nerve to nerve cell or nerve to muscle. Magnesium causes anæsthesia and paralysis, which is neutralised by calcium. On the other hand Sabatini states that a solution of calcium applied to the brain reduces its irritability, while salts that precipitate calcium increases its irritability.

According to Noel Paton there is yet another metabolic error in tetany. He finds that there is an excess production of guanidine and methyl-guanidine in parathyroidectomised animals and also in tetanic children. This he has shown both by metabolism experiments and also by blood analyses. His work has not, however, yet been confirmed, and doubt has been cast on the delicacy of his analytical methods. However, in the search for the origin of the circulating poison these results should not be overlooked.

Another interesting observation on tetany has been made by Uhlenhuth in America. He found that on feeding larval amblystoma on thymus they developed convulsions in their legs and tails, and in severe cases generalised convulsions. Amblystoma are a sort of tadpole which never naturally grow to the frog stage, but live and reproduce in their larval state. It is of interest to note that they do not possess parathyroids. By feeding them on thyroid, however, they can be persuaded to grow up into a form resembling the adult salamander. When they undergo this metamorphosis they develop parathyroids, and simultaneously thymus feeding fails to produce tetany. Feeding larval salamanders who possess parathyroids on thymus does not produce tetany.

This last work led me to look up the effects of the thymus, a gland which apparently only one observer (Basch) has ever connected with tetany. Extirpation of the gland causes

1. Changes in the bones. They begin to bend as in rickets, and the epiphysis shows irregular cartilage formation.

2. A diminished calcium retention and a lowering of the total calcium in the body. Fractures of bones do not heal with so much callus as is normal.

3. An increase in the nervous irritability to electrical stimuli exactly similar to that found in tetany but perhaps not so marked.

4. In those cases that die, an anæmia or cachexia.

There is less evidence as to the results of "hyperthymus" secretion. In myasthenia gravis, which disease according to Chvostek is the exact opposite of tetany, and which bears the same relation to tetany as Graves' disease does to myxœdema, there is a marked persistence of the thymus. Chvostek, however, considers this disease to be a hyper-*para*-thyroidism. Extract of thymus if not allowed to decompose or to be otherwise destroyed causes in some animals a paralysis of the legs. The thymus

thus apparently has some effect on the neuro-muscular system.

The only other form of tetany is that found in adults. This usually follows a dilated stomach, persistent diarrhœa, pregnancy or lactation, all being conditions in which a strain is being put upon the normal body metabolism.

Which of these many factors produces tetany in infancy? The parathyroids are the most popular scapegoat. Microscopical examination of the parathyroids of tetanic children often shows signs of old or new hæmorrhages or of inflammation. There remains, however, in the majority of cases quite a large percentage of the gland uninjured, and also in many children lesions of equal or greater severity have been found without a trace of tetany. This seems to point to the fact that the parathyroids unless badly damaged can carry on in a normal infant without tetany, but that if some other factor arises they are unable to cope with it and tetany ensues. What is this factor? We have many to choose from. The whole of the etiology of rickets is at our disposal. That which causes rickets will thus cause tetany as well if there be a lesion of the parathyroids. I cannot here discuss the pros and cons of the causation of rickets, as it is by far too great a subject.

Another possible factor is the calcium of the blood. Why is it reduced? Is it because the parathyroids control calcium metabolism or is it an index of some deeper disturbance? And again, is the increased nervous irritability due to this lessening of calcium or to this other unknown disturbance. The evidence at hand is entirely inadequate to settle this, and one can only propound these two theories:—

(a) Calcium metabolism is under the control of the internal secretion of the parathyroids, and that deficiency in this prevents the tissues retaining calcium, thus leading to diminished calcium content and thus causing tetany.

(b) Certain toxic bye-products (cf. Paton's guanidine experiments) are normally dealt with by the parathyroids and in children perhaps also by the thymus. The method of dealing therewith may be perhaps by combination with calcium. In disease more toxins are out-poured, and the calcium in the blood rapidly used up, the symptoms being then due to the uncombined toxic substances in the blood.

Both these theories explain how calcium would be curative in tetany; the second one, however, brings in adult tetany, as all the causes of adult tetany are conditions in which the blood is being flooded with toxins. Also the presence of infections either gastro-intestinal or respiratory have long been connected with tetany.

Yet another factor might be disturbance of the internal secretion of the thymus. The typical catarrhal child who has not yet developed rickets or tetany has usually a large thymus. It usually is easily tired and its muscles lack tone, a condition comparable to myasthenia gravis, and which might be regarded as the result of hyper-secretion of the thymus due either to hereditary or to chronic infection. Just as hyperthyroidism with hyperplasia of the thyroid may go on to myxœdema without diminution in size of the goitre so may the thymus atrophy and give rise to those symptoms described under extirpation of the gland—that is, ricket like changes in the bones, diminished calcium retention, and heightened electrical excitability.

Large fatty thymuses are regularly found in deaths from tetany, a fact noted by Marshall Hall in 1844 and to which condition nowadays the title status lymphaticus is given.

The fact that tetany is peculiarly a disease of the first few years of life, a time when the thymus is at its maximum and thus is most necessary to the welfare of the organism, adds weight to this theory.

Prognosis.

The prognosis of tetany varies with the age, severity and concurrent complications.

Repeated convulsions are of bad omen, and if not leading to death may cause a certain backwardness of the intellect. Tetany complicating acute diseases or rickets adds to the gravity of the condition. Laryngospasm also is a cause of death. Uncomplicated tetany, however, has a good outlook, and with proper treatment no untoward event should occur, especially if in a child over two years of age. The prognosis of latent tetany is always good.

Prophylaxis.

Tetany is rare in breast-fed children, and so one's first thought should be to insist on every child being breast fed. Proper dieting and good hygienic conditions afterwards should ensure complete freedom from the disease.

Treatment.

The immediate treatment of the more serious manifestations of this disease is of some importance. "Summoned to a child in convulsions, a physician should go at once and remain until the attack has subsided; he should take with him chloroform, a hypodermic syringe with morphia, a soft catheter or rectal tube, and a solution of chloral" (Holt).

Chloroform can be safely given to a child at any age, and should control the convulsions temporarily, or a cold pack to the head and a mustard pack to the body (this is better than a hot bath) are also very efficient in stopping mild cases of convulsions.

If these measures do not control the convulsions chloral should be given per rectum, injected high with a catheter. It can be given in warm milk; 4 grains can be given to a child of six months and 8 grains to a child of two years. If after 20 to 30 minutes this has not acted an injection of morphia should be given. A child of six months can be given 1/40th grain, one year 1/20th grain, and two years 1/16th grain.

If after this the convulsions still frequently recur magnesium sulphate can be injected, a child of three months being given 8 grains, and at nine months 20 grains.

Lumbar puncture sometimes relieves obstinate convulsions.

For laryngospasm a hot sponge to the larynx and cold water to the face and chest will usually relieve the spasm, and then chloral or antipyrin may be given.

Having dealt with the acute emergency, general treatment may be undertaken. Calcium acts in *tetany as quinine in malaria and thyroid in myxœdema*. Given in large doses, 7-15 grains of calcium chloride every four hours, it rapidly reduces the condition, and within 48 hours the electrical condition of the nerves returns to normal. It should be kept up for some time. Calcium lactate may be used, but it not absorbed so well. Alternatively, persistent drugging with chloral and bromide may be tried, and this also keeps the disease in check. The older forms of treatment have now fallen into disrepute amongst most people, but some still linger. These were leeches to the head, lancing the gums daily, persistent purging with calomel, and even bleeding.

The diet is of importance. For some reason cow's milk is very badly tolerated by these children, and should be cut down to a minimum. If, however, the reduction of milk affects the child's health adversely it should be increased, as tetany is the lesser evil, and can be kept in check by drugs. In children under eight months human milk acts like a charm, and should always be given if possible.

Honours.

O.B.E.

Lt.-Colonel H. M. Bromfield, V.D., R.A.M.C.(T) (retired), for medical services.

Foreign Decoration: Royal Air Force.

Chevalier de l'Ordre de la Couronne conferred upon Hon. Major Herbert J. Corin, O.B.E., L.D.S., by the King of the Belgians.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—Reading Mr. Fagge's clinical lecture on Circumcision, in the Gazette of April 3rd, 1920, I see he says that Nurses advocate circumcision, whilst in the house, so as to be able to charge an extra fee. My experience (as well as that of a good many others) is that the nurse has all the extra work it entails while the doctor takes the extra fee.—Yours truly,

A GUY'S NURSE DOING MATERNITY WORK.

Sir,—In the report of an abstract of a clinical lecture on Circumcision in your last issue, the fact is recorded that it is a very general practice to perform this operation upon the infant before the nurse leaves the house. A correspondent is quoted as saying "that one of the greatest advocates for this seems to be the Nurse, who, of course, gets an extra fee." Agreed that the nurse has been taught wrongly, and that it is out of her province to make suggestions, I have met, however, a large number of maternity nurses (mostly of Guy's) and my experience is that the nursing attendant upon circumcision and vaccination is expected of the maternity nurse—as part of her inclusive and multitudinous duties—and invariably given. Also I have yet to meet the nurse who would advocate any form of treatment because her fees thereby would be enhanced.—Yours, etc.,

S

Sir,—T.M.B.'s intriguing letter in your last issue provokes me—at the risk of being wearisome—to a few words of protest. The myth of the well-educated prostitute is so old—and one had thought so often exploded—that it is refreshing to find another victim of the "clergyman's daughter" story. Shaw in one of his prefaces says that you may search Europe in vain for a prostitute with the table manners of a lady, a statement which I have never had any reason to doubt.

He asks if prostitutes are recruited from the women workers of Cradley Heath (*chain* makers not chair makers, Mr. Editor, please) and from domestic drudges? My reply is most certainly Yes. Equal wages would doubtless fail, if by failure is understood the removal of every prostitute from the streets of London—there will inevitably be a few who prefer to lead a gay life (save the mark!) to working for their bread, but apart from an inconsiderable number of shirkers and degenerates the vast bulk of prostitution is, I am convinced, caused by oppressive industrial conditions.

With regard to the pledge of secrecy, the relation of the medical officer in a venereal clinic in no way differs from that of the ordinary medical practitioner to his patient. For some years now it has been an accepted common law ruling that such professional secrecy cannot be held binding in a court of law, and it is difficult to see why this class of case alone should be held immune. The secret treatment inducement must surely be held to mean that reasonable precautions are taken to prevent fellow patients being aware of the sufferer's identity, not that the law of the land is inoperative.

G.H.F.G.

Dear Sir,—I am directed by the Vice-Chancellor to inform you that the Senate have decided to hold a Graduation Dinner this year at the Guildhall on Wednesday, 19th May, at 7.30 for 7.45 p.m.

The Lord Mayor and the President of the Board of Education, among others, have intimated their intention of being present.

Tickets for the dinner will be one guinea each, including wine. The preliminary arrangements are now being made, and further particulars will be forwarded to you at a later date. It has been thought wise, however, to let you have this early intimation in order to avoid as far as possible College functions being fixed for the same day.—Yours faithfully,

VERNON E. WALL,
Acting Secretary, Establishment and General Purposes Committee.

University of London,
South Kensington,
London, S.W.7.
18th March, 1920.

The Value of Military Surgery in Civilian Practice—Results of Anociation in Reducing Mortality.*

In addressing the 73rd Annual Meeting of the Ohio State Medical Association (Journal O.S.M.A., September, 1919, p. 541), George W. Crile, of Cleveland, emphasised the value of Anociation in reducing operative mortality.

"The Interallied Surgical Conference," said Dr. Crile, "adopted as one of its conclusions that in the treatment of wounded soldiers the anæsthetic of choice is nitrous oxide-oxygen combined with local anæsthesia. Among the evidence offered in support of this tenet Surgeon-General Sir Anthony Bowlby presented the work of one of the most brilliant British military sugeons, Captain Douglas C. Taylor, and the work of the Chief of the Anæsthetic Service of the British Army, Captain G. Marshall. The experience of Captain Taylor I am privileged to quote. He has summed it up as follows: 'Until the summer of 1917 my colleague, Captain G. Marshall, invariably gave ether for my laparotomies for gun-shot wounds of the abdomen. No series of 100 consecutive cases showed a recovery rate of much over 50 per cent.

"'During the summer and autumn of 1917, I did 101 laparotomies for abdominal wounds, and nearly-half of them were given nitrous oxide and oxygen combined with infiltration of the abdominal wall with eucain and novocain. The more serious cases, i.e., those with rapid pulse and low pressure, were nearly all done by this method.

"'Of this series, 27 died at the Casualty Clearing Station, and 74 were evacuated to the Base; of the latter there have been only two deaths, both from secondary hæmorrhage—one from the kidney and the other from the rectum and buttock.'"

That is, by the employment of anociation, Captain Taylor's mortality rate was reduced from approximately 50 per cent. to 29 per cent.

Captain Marshall has demonstrated that patients may apparently do well during ether anæsthesia but do badly afterward, while they do well both during and after nitrous oxide-oxygen anæsthesia.

The experience on a large scale of the resuscitation teams from the Lakeside Unit which served continuously throughout Field Marshall Haig's great offensives in Flanders in 1917, during which there were over 800,000 casualties, showed that in abdominal operations somewhat better results were obtained if, before the beginning of the operation, sufficient blood were transfused to permit a safe performance of the operation; and again, at the completion of the operation, an ample amount of blood up to 750 c.c. were given. Furthermore, if a let-down appeared later, the transfusion might be repeated. Meanwhile the advantages of comfort, rest, warmth, morphia and fluids were added.

The advantages of the nerve-blocking are further emphasised by Colonel Cabot's series of 180 amputations of the thigh, one-half under ether, and one-half under spinal anæsthesia with a reduction of mortality by the use of spinal anæsthesia of 50 per cent.; while Captain Taylor by the use of nitrous oxide-oxygen reduced his mortality rate for thigh amputations more than 200 per cent.

*Communicated by the National Anæsthetic Research Society of America.

Appointments.

Medical School Appointments

April 16th—July 15th, 1920.

Surgical Ward Clerk.—Messrs. H. P. Baylis, I. J. Bechal, Hale-White, W. G. R. Hore, J. S. Hudson, C. L. Kark, L. H. B. Macleod, M. Markiles, C. C. Po, W. N. Ramsden, D. G. Sharp, J. Sullaiman, D. A. Windemer.

Clerks to Medical Unit (first three months).—Messrs. E. R. Boland, H. B. Flooks, H. A. Harris, M. M. Hegab, B. L. Laver, M. Mackenzie, C. F. Parry, J. F. Payan, H. Richards, H. K. Wallace, F. W. Widgery.

(Second three months).—Messrs. M. E. Shaw, T. J. Lane.

Dressers to Surgical Unit (first three months).—(Sir A. Fripp and Mr. Turner) Messrs. J. K. Milward and T. E. Jones; (Mr. Steward and Mr. Hughes) Messrs. A. R. Patel and D. Davies; (Mr. Fagge and Mr. Davies-Colley) Messrs. M. A. El-Biblawi and C. Shepherd; (Mr. Rowlands and Mr. Bromley) Messrs. H. B. Jones, A. Douthwaite, and A. T. Rogers.

(Second three months).—(Sir A. Fripp and Mr. Turner) Messrs. B. Kessel, E. H. Richards, and J. N. Alexander; (Mr. Steward and Mr. Hughes) Messrs. R. J. Hopkinson, H. W. Harvey, and C. M. Short; (Mr. Fagge and Mr. Davies-Colley) Messrs. G. B. Kirkland, A. E. Strawbaun, and H. O. Eksteen; (Mr. Rowlands and Mr. Bromley) Messrs. E. Hardy, M. H. Mackeith, and M. T. Ahmed.

Clerks in Department for Children.—

A. *Dermatology.*—Messrs. G. C. W. Felce, W. R. G. Hearnden, I. B. McCann, A. H. Shellswell, W. Summerskill.

B. *Neurology.*—Messrs. S. Annecke, K. J. H. Davies, G. W. Elkington, J. J. F. Rooney.

Obstetric Dressers and Extern.—(Mr. Bellingham Smith) Messrs. I. W. Arnovitch, E. C. Faraker, M. Hall, O. T. Maclaren; (Mr. Chapple) Messrs. J. T. Jones, J. B. Gregor, L. K. Watson, L. R. A. Wells, P. Richardson.

Clerks or Dressers in Special Departments—

Ophthalmology (Mr. Ormond) *and Laryngology* (Mr. Mollison)—Messrs. P. Couacoud and M. Maizels.

Ophthalmology (Mr. Eason) *and Laryngology* (Mr. Layton)—Mr. M. Mackenzie.

Ophthalmology (Mr. Ormond) *and Dermatology* (Dr. Barber)—Mr. I. Rosenberg.

Laryngology (Mr. Mollison)—Mr. J. A. Berry.

Genito-Urinary—Messrs. G. C. W. Curson and A. Mikhail.

Orthopædics—Messrs. F. L. Rayner and A. Mikhail.

Clinical Assistants.—Messrs. W. Mark Brown, E. E. D. Gray, P. J. O'Meara, R. M. Patterson, W. R. Remington.

Student Demonstrators of Anatomy.—Messrs. R. Brooke and J. A. Currie.

Guy's Hospital,
10th April, 1920.

H. Gardiner, M.B., B.S., F.R.C.S., to be Surgeon to Out-Patients, Evelina Hospital.

F. D. Saner, M.B., F.R.C.S., has been appointed Surgeon to Out-Patients, Great Northern Central Hospital.

Wilson Tyson, M.A., M.D., B.C., F.R.C.S., has been appointed Medical Referee to the Ministry of Pensions, Lowestoft District.

H. V. Leigh, M.B., B.S., M.R.C.S., L.R.C.P., has been appointed:—(1) Public Vaccinator to the Treharris District of the Merthyr Tydvil Union; (2) Medical Officer to the Post Office and Board of Education, Treharris District; (3) Certifying Factory Surgeon to the Nelson District; (4) Medical Referee for Treharris, Abercynon and Penrhewceiber Districts.

Pass List.

University of London.

First Examination for Medical Degrees.

March, 1920.

I. M. Benjamin.	E. F. Hewitt.
M. F. Butler.	H. Lewis.
G. Davies.	M. Rubinstein.
T. M. Fripp.	M. Taylor, B.Sc. (War)
C. S. Hallpike.	J. D. S. Thomas.
	Eric Wornum.

Second Examination for Medical Degrees.

March, 1920.

Part I.

*T. S. Blacklidge.	G. O. Mitchell.
A. H. Brockbank.	M. Mitman.
W. L. Cann.	P. McGregor Moffatt.
R. J. Cann.	G. H. Pitt.
R. S. Chambers.	A. T. W. Powell.
F. F. Gibberd.	W. G. Sears.
E. J. Greenwood.	M. B. Seng.
L. G. Housden.	H. C. C. Taylor.
F. C. Miller.	J. L. le Cun Walker.
	S. C. H. Worseldine.

*Awarded a mark of distinction.

Part II.

J. A. Currie.	W. A. Hawes.
G. B. Dowling.	C. F. Parry.
L. Gill.	W. M. Ramsden.

A Case of Hysterical Paralysis and Abdominal Pain Cured by Suggestion.

J. D., aged 25, was admitted to Mary Ward under the care of Dr. Hurst, for inability to use her left leg and also for pain in the same limb. She complained of indigestion and tenderness all over her abdomen.

Except for the fact that the patient's mother had similar symptoms when *she* was a girl, the family history is unimportant.

The history of the illness goes back some eight years, when patient began to suffer from indigestion and flatulence. The symptoms improved after her marriage, until she underwent her second pregnancy, when they all recurred. Following on the death of her second child, the patient had a so-called "nervous attack," and these "attacks" have been repeated seven times during the last eighteen months. During the latter period the taking of food has invariably been followed by pain.

On admission, the patient complained chiefly of weakness, pain and inability to use her left leg, dating back to her last nervous attack in February, 1920. The pain was situated in the ankle and back of the knee. All the systems were perfectly normal; the plantar reflexes were flexor, there was no ankle clonus, but the left foot was dropped; it could, however, be completely dorsiflexed; nevertheless, the patient was unable to walk at all. Patient was exquisitely tender on light abdominal palpation, but not on deep palpation.

Radiographic examination showed no abnormality beyond ptosis of the stomach. A fractional test meal showed very marked hyperacidity and also pointed to the presence of gastric delay.

It was suggested to the patient that she could keep her foot up, if she tried; this she was eventually able to do. The next step in the treatment was to get the patient out of bed and encourage her to walk. With the recovery of normal function in the foot—accomplished in the course of four or five days—the various other aches and pains that patient complained of disappeared.

This case was diagnosed by Dr. Hurst as one of a purely hysterical nature, and the diagnosis has been verified by the subsequent success of treatment by suggestion.

S. T. BARRETT.

A Case of Hirschsprung's Disease, causing Acute Obstruction.

By I. TEWFIK, M.R.C.S. Eng., L.R.C.P. Lond.

(Reprinted from *THE LANCET*).

The following case is of interest both from the point of diagnosing the condition, which is rare, and also from the point of being simulated by an acute obstructive condition which seldom manifests itself in cases of Hirschsprung's disease. The method adopted in the operative technique is to my mind the most suitable, as it alleviates the shock, and gives a chance to the affected colon to recover and decrease in size—two essential factors in the success of the anastomosis after the resection.

S.L., aged 10, was admitted to hospital on Oct. 27th, 1918, with symptoms of acute intestinal obstruction. Temperature 99°F.; pulse 120, rather feeble. He had been vomiting two days previously.

Previous history.—Five years ago he was admitted to one of the London hospitals, because "the child was always delicate, his stomach was getting bigger, and his bowels very constipated." Often his bowels did not act for a week or ten days. He was in hospital then for about six months with no apparent benefit.

Examination.—The child looked ill, with a furred tongue and the anxious expression indicative of an acute abdomen; his abdomen was protuberant and hard, especially in the lower half. On percussion a dull note was elicited over the greater part of the lower abdomen. The child otherwise looked quite normal.

Operation.—I decided to operate at once, and the abdomen was opened through a right paramedian incision. The condition suspected was revealed straight away; in the abdomen was a reddish-blue mass which looked like a twisted ovarian cyst. The tumour really consisted of the descending and pelvic colons greatly distended and full of fæces; the colour was due to the stagnant fæces infecting the bowel wall. I decided to relieve the obstruction first and give the distended and infected diseased colon a chance to improve, and also to lessen the shock of the operation, a matter of vital importance. Through a left gridiron incision I brought out the proximal end of the descending colon, which was quite healthy, after cutting it away from the rest.

The distal end was closed up securely with sutures and returned into the abdomen. By the help of my assistant, who dilated the rectum, I was able to empty the contents of the diseased colon. A Paul's tube was inserted in the colotomy. The child was infused through the axilla during the operation. Daily rectal washouts were given to disinfect the colon, which was obviously in an infected condition, and the child made an uninterrupted recovery. On December 3rd I decided to complete the operation. The abdomen was opened through a left paramedian incision; subcutaneous saline infusion was given in the axilla . The diseased colon was found to have decreased in size and was in a much healthier condition. It extended far down in the pelvic colon, which made the resection and the subsequent end-to-end anastomosis rather tedious. The abdomen was closed in the ordinary way and a drainage-tube inserted through the old colotomy incision. Before closing the abdomen a stomach-tube was passed from the rectum past the anastomosis. The bowels acted regularly on the third day, and then daily afterwards till the ninth day, when fæces were noticed to appear through the old colotomy wound. The patient ran an irregular pyrexia for three weeks, beginning one week after the operation. His bowels still acted normally every day while the fæcal fistula was discharging, some days more than others. The fistula eventually closed entirely on March 27th, 1919, and remained closed till his discharge on May 19th. His bowels since the second operation acted normally and regularly every day; the child improved considerably, putting on weight, and looked altogether different. I have recently heard that his fistula broke down, but I presume it will soon close up again.

Guy's Hospital.

SUMMARY OF ACCOUNTS, 1918-1919.

COMPRISING THE

LIGHT DEPARTMENT, NEW ELECTRICAL DEPARTMENT, SURGICAL RADIOGRAPHIC DEPARTMENT, MEDICAL RADIOGRAPHIC DEPARTMENT, PHOTOGRAPHIC DEPARTMENT.

	1918.			1919.		
Light Department—	£	s.	d.	£	s.	d.
New Apparatus	10	10	0	20	3	0
New Tubes	61	14	9	132	14	4
Tube Repairs	18	2	0	69	5	3
Maintenance and Sundries	24	3	0	103	13	11
	114	9	9	325	16	6
New Electrical Department—						
New Apparatus		15	0	11	5	0
Maintenance and Sundries	19	8	10	35	7	3
	20	3	10	46	12	3
Surgical Radiographic Department—						
Plates	219	10	3	560	14	8
Paper	11	12	3	31	7	9
Photographic Sundries ...		6	4	9	3	6
New Apparatus	8	10	5	292	10	0
New Tubes	60	0	0	54	0	0
Tube Repairs	28	15	0	2	17	6
Maintenance and Sundries	9	16	10	20	18	0
	338	11	1	971	18	5
Medical Radiographic Department—						
Plates	181	18	9	298	11	4
Paper	8	4	0	25	9	0
Envelopes	3	9	9			
Photographic Sundries ...		5	0	1	2	1
New Apparatus	6	0	0	38	18	6
New Tubes	44	5	0	106	16	6
Tube Repairs	70	17	6	15	12	0
Maintenance and Sundries	13	16	0	34	4	6
				520	13	11
By Credits				7	12	6
	328	16	0	513	1	5
Photographic Department—						
Plates	20	18	2	24	12	0
Paper	9	5	0	18	19	0
Photographic Sundries ...	1	11	9	11	1	8
	31	14	11	54	12	8
Massage Department—						
Special Repairs		12	0			
		12	0			
Theatres—						
Maintenance	3	18	0			
	3	18	0			

Given the quantities of plates (in dozens) and paper (in packets) used in the various Departments for 1918 and expenditure thereby entailed set to unity factors, the ratios of increases for 1919 in these Departments are set out as follows:—

Surgical Radiographic Department—
Plates, 2·41; Expenditure, 2·53.
Paper, 1·20; Expenditure, 2·70.

Medical Radiographic Department—
Plates, 1·70; Expenditure, 1·64.
Paper, 2·52; Expenditure, 3·10.

Photographic Department—
Plates, ·92; Expenditure, 1·18.
Paper, 1·98; Expenditure, 1·99.

Reviews, etc.

Sussex in Bygone Days. Reminiscences of Nathaniel Paine Blaker, M.R.C.S. (Messrs. Combridges, Hove, Sussex, 1919—price 5s.).

For those who are lovers of Guy's, equally with those who are lovers of Sussex, and for all who can take delight in that pleasant form of history which only the personal reminiscences of a keen observer and a wise old man can provide, this small volume should prove a valued acquisition. We would particularly recommend that the Library Committee hasten to obtain a copy of the book for that section of the Wills' Library which is devoted to the works of Guy's men. Nathaniel Paine Blaker was born in 1835, and only recently finished his full and busy life. The son of a Sussex farmer, and well versed himself in the lore and caft of the countryside and in a knowledge of agricultural problems, he obviously found through all his medical life in the town great pleasure and a sense of tranquillity in his thoughts of earlier years and earlier ways, and to the end could not quite accommodate himself to a full belief in the virtues of progress. Nor can we blame him in this, for, despite the advantages of modern life, with its increased facilities for travel, its rapidly striding sciences, its improved education and other benefits, we know that we have lost much in simplicity and quietude, in physical and to a great extent in moral standards, and that many of us are not such sterling men as were our fathers. However, such criticisms as he includes are all gentle and philosophic, and are themselves as enjoyable as the old-world pictures which he paints. The book is concerned partly with Sussex and the people of Sussex 50 years and more ago, and partly with the medicine and surgery of those and succeeding days. The author was trained at the Sussex County Hospital, on the staff of which he later served as a surgeon for many years, and also at Guy's Hospital. He watched the whole evolvement of his science from the pre-Listerian period to the present day, and himself in his own locality contributed not a little to its advances. His chapter entitled "Altered Type of Diseases in Relation to Social Customs" which concludes the book gives much food for reflection, and the reader cannot help being impresed by the solid basis of long experience upon which its observations are built, as well as by the thoughts and simple style and humour of the writer in this and other sections of his reminiscences. The interest of the book to Guy's men and medical men generally is further enhanced by a foreword by Habberton Lulham, another son of Guy's and Sussex, and an introductory letter by Sir Arthur Newsholme. The arrangement and form of the volume well become the subject with which it deals.

Cunningham's *Manual of Practical Anatomy.* Edited and revised by Arthur Robinson. (Messrs. Henry Frowde and Hodder & Stoughton) 7th edition, Vol. 2.

We must extend a hearty welcome to the new edition of Cunningham's Manual as revised by Professor Robinson. It has been enlarged by the addition of new illustrations and radiographs, and by expanding the dissection instructions, which now appear in distinctive print. Owing to the new matter thus introduced it has been found more convenient to issue the Manual in three volumes instead of two as heretofore. The second volume contains the thorax and abdomen, and the third will be devoted solely to the head and neck. The Manual remains what it has always been—the best book for the practical study of the anatomy of the body. We would, however, like to express our regret that the editor has not taken this opportunity of reverting to the old nomenclature, instead of retaining the Basle terminology. Whatever may be the state of affairs in Edinburgh and Scotland generally, we have no doubt that the B.N.A. has been almost entirely discarded in the London anatomical schools, and has certainly found no favour in the surgical wards of hospitals. Anatomical nomenclature at the best is confusing enough, and it is too bad for the student to have the additional disturbing factor introduced of being taught in one terminology and reading his text-book in another. We hope that Professor Robinson will seriously consider this aspect of the question, and by reverting to the old terminology add to the already great popularity that his text-book enjoys.

Sight Testing Made Easy. By W. Wright Hardwicke, M.D. (St. And.), M.R.C.P., L.R.C.S. (Ed.). (Messrs. Churchill) 4th edition, price 5s.

The popularity of this little book is evident from the fact that a fourth edition has been published. The main part of the book deals with the subjective methods of sight testing. A short chapter on Retinoscopy, however, has been added. The book is a concise and practical summary of the art of sight testing, and we heartily recommend it as an introduction to a more complete study of the subject.

W. G. Porter's *Diseases of Nose and Throat.* Revised under editorship of A. Logan Turner, M.D. Ed., F.R.C.S.Ed. (Messrs. John Wright & Sons, Ltd., Bristol) 3rd edition, price 7s. 6d.

The third edition of this book has been revised by some of the late Dr. Porter's colleagues, under the editorship of Dr. Logan Turner. The general

character of the book has in no way been altered in the present edition, the revisers having kept in mind the author's main object in writing the book for practitioners and senior students. The book is well written, easily read, and essentially practical. We would draw attention to the chapter on the Examination of the Ear, and especially to the section dealing with the vestibular tests. The various operations mentioned are such as can be done by practitioners who have made no special study of the subject. There is also an appendix containing some useful prescriptions. We have no hesitation in recommending the book to those for whom it has been written.

Exhibition to Help Aged Artist.

Arrangements have been completed for the exhibition (to which reference was made recently in *The Times*) of the pictures of Mr. Horace Van Ruith, the artist, who is over 80 years of age and is now blind. By permission of Sir James Cantlie, and with the approval of the president and governing council of the College of Ambulance, the pictures will be exhibited in the grand hall of the College, 56, Queen Anne Street, Cavendish Square, from April 19th to 24th. Many of the pictures have been exhibited at the Royal Academy, and others include a number of Indian studies. The object of the exhibition is the sale of the pictures in order to buy an annuity which will enable the artist to live in comfort during the closing years of his life. Mr. Van Ruith painted portraits of the King and Queen when they were Prince and Princess of Wales, and these now hang in the Government House, Mauritius. The exhibition will be open daily from 11 to 6.

Athletic Club.

The first General Meeting since the war of the above Club was held in the Anatomical Theatre on Tuesday, March 30th, 1920. About 12 men in all were present, with Dr. Fawcett in the chair. The chief business was the election of the following committee:—

President, Dr. John Fawcett, M.D., F.R.C.P.; hon. secretaries, Messrs. R. S. Chambers and L. G. Housden; hon. treasurer, Mr. Fry; committee members, Messrs. C. L. Steyn, M. V. Ward, C. T. V. Baugh, C. W. Greenway, K. J. Davies, J. A. Currie, A. H. Shellswell, L. K. Watson, F. W. Crook, W. D. Doherty, R., J. Hodgkinson.

It was further decided to hold the annual sports this year, and, further, that in all probability the Inter-Hospital Sports Meeting will be held early in June, and in view of this it has been suggested that our own meeting should be held on Monday, May 24th. The date, however, will be confirmed at a Committee Meeting.

Football.

CUP TIE.

The final of the Junior Inter-Hospital Cup Tie between Guy's and "Bart.'s" was played at Chiswick, St. Thomas's Hospital Ground, on Saturday, March 20th, in weather more suitable for cricket than football.

From the start Guy's were the better side, and led at the interval by two goals to nil. Both goals were scored by Smith, after some good combination among the forwards, in which Van Schalkwijk took a prominent part.

In the second half Guy's pressed continually, and but for some erratic shooting would have won by a much bigger margin. Van Schalkwijk settled the issue ten minutes from the end by running through the opposition from half-way and scoring a delightful goal.

Guy's team:—E. Hardy, F. Biddle, D. C. Robertson, E. F. Wilson, R. F. H. Duncan, J. C. Hewetson, W. Heming, F. E. Jones, F. Smith (Capt.), J. Van Schalkwijk, and W. G. Caldwell.

Remarks.—The Guy's team, strengthened by the inclusion of the three "Rugger" men, have never played better, and were full value for their 3—0 victory. Hardy, in goal, did what little he had to do, well. The backs were good, Biddle's kicking being excellent. Duncan at centre-half was a tower of strength, both in attack and defence, in which he was ably assisted by the wing halves. All the forwards were good, "Tiny" Caldwell and Van Schalkwijk making a fine combination.

The report of the University of London Cup Final is unavoidably held over till the next issue.

List of Blues and Half Blues awarded on 31st March.

RUGBY.

Full Blues.—J. A. Krige, H. G. Davies, P. J. Krige, F. Bekker, J. Van Schalkwijk, C. Marais, A. H. Shellswell, G. Kidman.

Half Blues.—W. Olivier, E. L. Steyn, E. Neser, H. Van Zijl, R. F. H. Duncan, L. K. Watson, G. Zondagh, T. A. Shaw, A. Daneel, C. Pauw.

ASSOCIATION.

Full Blues.—G. P. Lindsay, D. J. P. O'Meara, D. H. Couch, R. Van Geens, R. Pengelly, L. A. S. Trott, A. W. Riddols, C. A. Wakeford, F. Rayner.

Half Blues.—J. R. Rowbotham, M. MacKeith, W. J. Hore, F. Smith, D. C. Robertson, J. C. Hewetson, W. G. Caldwell, E. F. Wilson.

Hockey.

Full Blues.—B. M. Tonkin, J. W. Schollum, J. R. A. Moore.

Half Blues.——. Bowen, —. Owen, J. E. Duckworth.

Hockey.

RESUME FOR SEASON 1919-20.

The past season may be regarded as very satisfactory, in that the Hockey Club was re-started after a lapse of five years, and we have to thank Mr. Vincent Brown for his untiring efforts in connection with the fixture list and the calling of of the first General Meeting.

The statistics of the matches stand as follows:—

Games Played.	Won.	Lost.	Goals For.	Against.
15	10	5	82	49

We were, however, unsuccessful in the Inter-Hospital Tournament, being beaten by a strong "Bart.'s" team.

Owing to the uncertainty of the support which would be forthcoming for the season 1919-20, it was found impossible to procure a ground, and all matches had to be played away. An excellent ground has been obtained for next season, and it is hoped that enough men will play to justify the full fixture list which is now complete for both First and Second XI.'s.

For the first half of the season Mr. G. L. Cutts, the only remaining 1914 "Blue," captained the side. Mr. Cutts being compelled to resign as he could not spare the time, Mr. B. M. Tonkin was elected.

Generally speaking, the play throughout the season has been good, and great improvement has been shown, particularly in the forward line. The defence perhaps has been a little on the weak side, but next season should see Guy's with a hockey team worthy of the previous Hospital records.

Among the forwards Schollum at centre was the most prolific goal scorer, while Orwen at outside left was very fast and centred well.

Of the halves Moore at centre was always to be relied upon, while Bowen at back was a tower of strength to the side.

The Second XI., when playing as such, has shown promise, and there appears some excellent individual talent requiring only practice and opportunity. This will undoubtedly be afforded by the fixture list for next season, in which the standard of opposing teams has been raised for both XI.'s.

Team:—C. Baugh, G. C. Bowen, H. C. Churchill, C. Shepherd, J. R. Moore, H. A. H. Harris, C. L. Orwen, D. C. Eglington, J. W. Schollum, B. M. Tonkin, and J. E. Duckworth.

H. A. H. HARRIS.

Notices.

Guy's Hospital Musical Society.

It has been decided to give a concert on Friday, May 13th. Subject to official sanction, the concert will be held in the Court Room at 8 p.m. As the seating capacity of the Court Room is necessarily limited, members of the Hospital and others who propose to come should apply early for their tickets, which, with all other information, may be obtained from the secretaries, Messrs. Maurice Shaw and C. E. Gallagher.

The Nurses' Cottage at Honor Oak Park has just been enlarged, and the grounds much improved by the addition of a second tennis court. Furniture is still lacking for a small sitting room and three bedrooms, and any contributions of suitable old furniture that any of our readers might feel they could spare, would be most gratefully accepted.

Such things as chairs, small dressing chests, tables, mirrors, fire-irons, and cupboards would be most useful.

Gifts should be sent to the Matron, Guy's Hospital, S.E.1.

Matron's Office,
Guy's Hospital, S.E.1.
April 13th, 1920.

Papers by Guy's Men.

Capt. D. Clewer, An Interesting Case of Epithelioma of the Buccal Mucous Membrane.—*B.D.J.*, April, 1920.

John Howell, F.R.C.S., "Acts of God" in the Sphere of Surgery.—*Clinical Journal*, February, 1920.

F. D. Saner, M.B., F.R.C.S., The Plating of Simple Fractures.—*Lancet*, April 10th, 1920.

Births.

TICEHURST.—On February 23rd at 24, Pevensey Road, St. Leonards-on-Sea, the wife of N. F. Ticehurst, F.R.C.S., of a son.

WARNER.—On the 1st April, at Rydal, Woodford Green, Essex, the wife of H. P. Warner, M.B., B.S., of a son.

Death.

ROPER.—On 3rd April, at "Colby," Lewisham Hill, S.E., Dr. Arthur Roper, in his 82nd year.

Ed.—M. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIV., No. 830.] MAY 1, 1920. [SIXPENCE.

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Passim.

WE have lately heard of certain suggestions in connection with proposed alterations in the structure and arrangement of the "College." The idea, as we understand it, is that the "College," as such, should be employed entirely for residential purposes, and that on the site of an adjoining warehouse a new building be erected to be used specifically as a Club.

This Club would include Dining, Smoking, and Reading Rooms, and possibly a billiard-room as well.

Since 1918 the number of Students entering Guy's has been steadily increasing, and now the present Dining Hall is incapable of holding them all. The Reading and Smoking Rooms, as well, have never been models of comfort and architectural design, and they, too, are becoming very overcrowded. For these reasons, therefore, we welcome the suggestions, outlined above, and hope that they will receive the careful consideration of everyone who is interested in the social life of the Hospital.

The scheme, we understand, has the support of the authorities, but before these really essential alterations can be carried out, a certain purpose. We shall be glad to hear the opinions of past and present Guy's men on this subject.

ON another page we print a letter dealing with the question of the Front Surgery Dresser. We have thought for some time that the new system of putting a man on duty in the Surgery for nine and a half hours at a stretch, is, to say the least, unphysiological. The Dresser examines his cases not so much by the light of experience and intuition, as by the exertion of commonsense based on theoretical knowledge. It is not hard for him to give every patient careful attention for the space of a few hours, but it is very difficult for him to do so at the end of a long day, when his mental processes have become dulled by sustained effort, and more especially by tying up cut fingers and applying innumerable dressings to whitlows and boils.

Though the O.P.O. is supposed to see all patients before they leave the Surgery, the demands on the Dressers' endurance are none the less for that, and the advantages that the latter's responsibilities — such as they are — should bring him, are minimised.

ON April 14th the majority report of the Royal Commission on Divorce was considered by the Houses of Parliament.

The Commission recommended (amongst other things) that (a) Incurable Insanity; (b) Habitual Drunkenness; (c) Infectious Venereal Disease; and (d) Husband or wife under a commuted death sentence, should form sufficient grounds for divorce.

To the ordinary individual of average intelligence, it would seem inconceivable for anyone to quarrel with the findings of the Royal Commission. Nevertheless, in the Parliamentary discussion, one member said that he did not see why divorce should be obtainable against the habitual drunkard and not against the drug habitué. When, therefore, the Government left the House to express its opinion by vote, this member voted against the motion! Another member in the Lords thought it absurd to grant divorce in cases of infectious venereal disease and *not* in cases of other infectious diseases (such as tuberculosis); he, *too*, voted against the motion. And Lady Astor did likewise, paradoxically enough, because she doubted whether the relaxation in the divorce laws would help the bulk of men and women in the country.

Surely there is enough unavoidable injustice and suffering in this country already, and we cannot afford to ignore any method by which the happiness of the people may be enhanced. The action of the House of Commons in expressing its disapproval of the findings of a *specially* chosen Commission is to be deplored and calls for criticism.

THE Physical Society has divided its Prize for the best paper read during the Session between Mr. W. Payne and Mr. R. Ledlie. Mr. Payne's lecture on "Tetany" has already appeared in the GAZETTE, and we hope to print Mr. Ledlie's paper on the "Parasitic Theory of Tumours" in our next issue. Both papers were very interesting, and considering the difficulty of comparing two essays on such widely different subjects as Tumours and Tetany, we think that the Committee of the Physical Society were well advised in making their decision.

WE publish on page 142 an excellent letter from Dr. Goodhart which embodies a plea for the adequate training of the medical student in pathology and allied subjects. In a previous "Passim" we had expressed our whole-hearted approval at the re-establishment of the old appointment of Surgical Ward Clerk. From our statements Dr. Goodhart has made some rather unjustified deductions. He infers that we do not consider instruction in pathology a matter worthy of serious consideration, and he deplores the fact that "the preliminary three months' course in various branches of pathology and elementary clinical methods has been dropped and the old arrangements reverted to." We certainly *do* think that these so-called elementary clinical methods can be learned in a quarter of the time. As for pathology, that is a different matter. We quite agree that *it* should receive just as much attention from the student in the wards, as does anatomy, in the early years of his study.

Hospital appointments may be divided into two classes—the busy ones and the slack. The former group includes Surgical Dressers and Externs; the latter includes Surgical and Medical Ward Clerks and Clerks in certain of the Special Departments.

Now people engaged on "slack" appointments should not find it difficult to devote a few hours a week to the study of pathology and

bacteriology, and such a study could, therefore, continue *intermittently* during the years that elapse between entry into the wards and final qualification, provided that a *continuous* course in these subjects were maintained throughout the year.

In this way pathology would receive the consideration that it obviously deserves, and the appointment of Surgical Ward Clerk, so satisfactory from all points of view, would continue unchanged.

ON the 28th April, 1920, the second number of the *Guyoscope* made its appearance in the Hospital. Its coming was unheralded and unsung; it fell upon us like a bolt from the blue—unexpected; but none the less welcome for that. Though it contains no material of superlative brilliance, still it is, on the whole, very amusing, and the *Guyoscope* Staff are to be complimented on their zeal in bringing out this number, and more especially in rescuing their paper from untimely extinction.

IT seems that the present Warden of the College—Mr. Bromley—will shortly be leaving the Maze Pond. Only the other morning we saw a furniture removal van outside his house. Mr. Bromley has administered the College for nine years, with great success and ever increasing popularity, and everybody in residence at the College will be very sorry to think that he is leaving us so soon.

University of Durham.

At the Convocation held on March 27th, 1920, the following degrees were conferred:—

M.D. FOR PRACTITIONERS OF FIFTEEN YEARS STANDING.

Charles Edwards.

M.B., B.S.

J. F. C. Braine.

H. S. GROVES, Esq., M.R.C.S.,
President of the Residents,
The College, Guy's Hospital, S.E.1.

DEAR MR. GROVES,

The Presentation Plate from the Staff, Students, Nurses, and Works Department has now been delivered at our new flat, and I wish to tell you how greatly both Lady Perry and myself appreciate the gift. May I add my personal thanks for what you did on this happy and sad occasion?

Yours sincerely,
E. C. PERRY.

Guy's Hospital Missionary Society.

RECEIPTS AND PAYMENTS FOR THE YEAR ENDED DECEMBER 31st, 1919.

RECEIPTS.

1919.	£	s.	d.	£	s.	d.
To Balance brought forward:						
Cash at Bank	16	1	4			
Petty Cash in Hand ...	—					
				16	1	4
,, Subscriptions and Donations				20	4	6
				£36	5	10

PAYMENTS.

1919.	£	s.	d.	£	s.	d.
By Subscriptions to other Funds	10	10	0			
,, Printing, Stationery, Magazines, &c.	1	17	6			
,, Postages		5	6			
				12	13	0
,, Balance carried forward:						
Cash at Bank	23	10	10			
Petty Cash in Hand ...		2	0			
				23	12	10
				£36	5	10

Audited and found correct,
W. J. CURRY.

January 20th, 1920.

Appointments.

Charles Edwards, M.D., M.R.C.S., has been appointed to the Commission of Peace for the Borough of Bridport.

S. W. Coffin, M.R.C.S., L.R.C.P., to be Anæsthetist to the Hospital for Diseases of the Throat, Golden Square.

Edward M. Mahon, M.R.C.S., L.R.C.P., Clinical Assistant to London Lock Hospital since May, 1919.

Diverticulitis of the Colon.

By R. P. ROWLANDS, M.S., F.R.C.S.

Stricture of the colon due to diverticulitis is of great practical interest to the surgeon, and has not received the attention it deserves, with the result that it is often mistaken for malignant disease. The clinical symptoms and physical signs may closely simulate those of carcinoma of the sigmoid colon. It is very difficult to distinguish the two conditions even when the abdomen is opened. The true nature of the disease may be realised only after resection or even after microscopic examination. When the extent of the "growth" or the condition of the patient in the presence of acute obstruction does not allow a radical operation, the mistake may not be discovered. The unusual prolongation of life after colostomy or the spontaneous disappearance of the "growth" may give an indication of the true state of things. Most of us know of several instances of this kind. The writer knows of at least three patients who have survived for many years after colostomy for supposed carcinoma of the pelvic colon. Many museum specimens long regarded as examples of carcinoma of the sigmoid are really inflammatory.

It is very easy to overlook these diverticula, especially when they are limited to the mesenteric border. They project into a greatly thickened mesentery, and their orifices are often so small that they can only be discovered by means of a probe. They are so hidden that they can be very easily overlooked. The writer would certainly have overlooked them if he had not previously read Dr. Telling's paper.* They are especially common at the mesenteric border following the blood vessels, where the muscular wall of the bowel is often deficient and ill-supported. The retention of irritating and inefctive material in the diverticula may lead to inflammation and even to perforation of the thin-walled sacs. This may be followed by spreading or localised peritonitis, but when the diverticula are deeply embedded in a thick mesentery the inflammation may be confined to the mesentery and the outer walls of the bowel. In some cases suppuration may take place between the layers of the mesentery, and pus may discharge into the bowel or into a diverticulum. In some it may burst into the peritoneal cavity. In many cases appendicitis may be closely simulated except that the swelling is on the wrong side. Sometimes the inflammation is more chronic and leads to much thickening and shortening of the mesentery and interstitial inflammation of the intestinal wall with secondary stenosis. The mucous membrane may remain fairly healthy for a long time. The condition is by no means limited to the sigmoid colon. Thus, in one of my patients it extended from the pelvic colon to the splenic flexure. In others it has been limited to the splenic flexure or to a short segment of the transverse colon. The formation of diverticula in the colon seems to be chiefly due to long-continued constipation associated with failure of the muscularity of the intestinal wall. It is, therefore, a condition which is not often seen before middle age, and Telling points out that "the average age of those in which the diverticula caused clinical symptoms was 55 years" (47 cases). It is, of course, admitted that the presence of diverticula is not the only cause of inflammatory stenosis of the large intestine. Tuberculous infiltration, especially of the cæcum and ascending colon, may closely simulate malignant disease. Gonorrhœal and tuberculous tubular stenosis of the rectum are well-known conditions. The spread of inflammation from the female pelvic organs may give rise to true stenosis of the sigmoid or pelvic colon.

Case I.* Mrs. M., aged 60 years, patient of Dr. J. Kidd. She had suffered from constipation for many years. There were only two actions of the bowels in a fortnight during May, 1908, while the patient was on a holiday at Lugano. The symptoms had got very much worse by July 21, 1908, when she was seized with severe colicky pains in the abdomen. The bowels were opened with difficulty, so that opening medicines had to be taken regularly and these were followed by liquid motions. During the last few weeks liquid stools and slime were frequent, but no formed motions were ever passed. Tenesmus had been very severe, and spurious diarrhœa urgent and often uncontrollable, so that a diaper had to be worn. Usually only mucus and flatus escaped, but this gave great relief. Flatulence had been very troublesome. The wasting had been very considerable. On examination the patient was found to be thin, shrivelled, and anæmic. The bowels had not been opened for three days. The tongue was furred and white, and the abdomen was distended but quite soft and supple. Obvious peristalsis could be seen, and this was especially marked in the transverse colon. The descending

The Lancet, March 21st (page 843), and 28th (page 928), 1908.

*Cases 1 and 2 were reported in *The Lancet*, 1910, vol. 1 (page 1,194). They have been followed up and their accounts completed.

and sigmoid colon could be felt in the iliac fossa, and the swelling and hardness extended up into the left loin and under the cover of the ribs near the splenic flexure, where the patient said that she had had much pain and had noticed gurgling. There was shifting dulness in the flanks. The transverse colon was greatly dilated. There was no tumour felt on pelvic examination. A systolic apical bruit was heard, and the ankles were œdematous. Chronic intestinal obstruction due to growth of the descending colon was diagnosed, and an operation advised for its relief. The patient expressed strong disapproval of colostomy, but this did not seem likely to be necessary, because either resection or lateral anastomosis was thought to be possible. Upon opening the abdomen on August 22nd about two pints of sanious fluid escaped. The colon from just below the sacro-iliac synchondrosis to the splenic flexure was greatly thickened, red, and œdematous. It formed a rigid tube with a very thick wall and very narrow lumen. The mesentery had shortened so much that only a very short meso-sigmoid could be found, and there was no sigmoid loop of bowel, but only a nearly straight rigid tube, ending abruptly at the splenic flexure. There was no meso-colon. The peritoneal tissues on either side and behind the colon were œdematous. In view of the patient's feeble condition and the presence of subacute obstruction which was nearly complete, and the condition of the distended transverse colon, which was full of hard scybala, immediate resection was considered inadvisable and too risky. Moreover, the extent of bowel to be removed was very considerable, and the patient had refused her permission to a colostomy. It was therefore decided to join the ileum to the front of the pelvic colon or rectum at the lower border of the disease. Even there the bowel was not quite healthy, and it was so fixed that the anastomosis was very difficult. The friable condition of the large intestine and the need to make the opening very low down added to the to the difficulties. However, with the aid of clamps and the Trendelenburg position, a side-to-side union was made between the ileum and the pelvic colon, the lower angle being about 5 inches from the anus. Three layers of sutures were used, one piercing all the coats, and two sero-muscular; and the great omentum was wrapped round the front and upper side of the anastomosis. The anæsthetic was ably given by Dr. F. E. Shipway, and Mr. Norman Flower, my house-surgeon, assisted at the operation. The pain and rectal tenesmus were greatly relieved by the operation, and death from intestinal obstruction was averted. At first the bowels were opened very freely, generally about six or eight times in 24 hours. The motions were usually liquid, very offensive, and often contained a little blood. Occasionally some scybala came away with the daily enema which was given. Sour milk was tried, and a variety of other things, without affording much relief. The abdomen remained rather distended, supple and flatulent. The motions gradually became less frequent and more solid. The thickened descending colon could be felt quite easily. The patient was able to leave the nursing home and return to her home considerably better 10 weeks after the operation.

Dr. Ryle kindly wrote again in December, 1919, saying: "She has gone on well on the whole, leading a more or less invalid life. She has suffered all along from great flatulent distension, and the bowels require occasional assistance with cascara. She has for the last two or three years had considerable enlargement of the heart and occasionally had fainting attacks. It is possible to feel two or three lumps in the region of the descending colon, but these have not changed since I first saw her after the operation. She has had no secondary acute condition of the bowel all along, but rarely indeed she has had one grain of calomel or an enema."

CASE 2.—A stout man, aged 49 years, was referred to me by Sir Wm. Hale White and Dr. C. J. Woollett in the middle of September, 1909. Dr. Woollett gave the following excellent history:—

"I have known Dr. — for about five years, during which time I have occasionally attended him for laryngitis (simple) and for shingles; his general health was good, and he weighed about 16 stone. This spring Dr. — consulted me about a pain from which he sometimes suffered on the left side of the abdomen. The pain was not constant, and, as a rule, not severe. He stated that he had had it on and off for the last 30 years, and that when he was a student a German doctor told him that he was suffering from enlargement of his colon. Dr. — told me that he suffered habitually from constipation, to overcome which, he was in the habit of taking purgative pills, and consequently had two or three actions of the bowels per diem; he did not pass blood. As a rule he had a good appetite, was a quick eater, and of a very energetic temperament. On inspection and palpation of the abdomen, and on rectal examination, I could detect nothing in the shape of a tumour. Deep pressure over the sigmoid caused some pain. The abdominal walls were then, rather fat. At the beginning of September I was again called to see my patient. He had lost about two stone since my last attendance, and had suffered frequently from his abdominal pain. At this date he complained of the pain being more acute, and he had had rigors on the previous day. I do not think he had vomited. On examination there was a temperature of about 102°, a quick pulse, furred tongue, and excessive tenderness on pressure over the sigmoid. The treatment consisted of hot fomentations and a febrifuge medicine and enemata. After a few days the temperature became normal, and the tenderness subsided, and then for the first time I discovered a tumour in the sigmoid region. I advised my patient to see Dr. Hale White, who sent him to you."

In the left iliac fossa a round movable swelling of about the size of a cricket-ball could be felt. It moved more freely from side to side than vertically. He suffered much from flatulence, indigestion and insomnia. His worst symptom was very severe tenesmus, which made him pay frequent visits to the lavatory, where he sometimes stayed for an hour at a time, without geting much relief, only passing mucus and flatus. Upon rectal and bimanual examination no tumour could be discovered in the pelvis or bowel. The diagnosis was somewhat uncertain, especially on account of the unusually long duration of the symptoms of obstruction and the history of rigors, but an exploration seemed to be imperative.

A growth of the sigmoid colon with inflammatory changes around it was considered to be the most probable diagnosis, but in view of the long history Sir Wm. Hale White suggested that the disease might be non-malignant.

The bowels having been cleared out as well as possible by means of castor-oil, the abdomen was opened through the lower part of the left rectus, and a tumour, thought to be malignant, was discovered near the middle of the sigmoid colon and its mesentery. The lumen of the bowel was considerably narrowed, but the bulk of the swelling was towards the mesentery, which was much shortened and very thick. Nodules, thought to be enlarged glands, also extended upwards along the inferior mesenteric vessels, for several inches. Resection was decided upon, although the condition did not appear to be a very hopeful one, because of the extensive infection of the lymphatic glands. The Trendelenburg position was adopted, and the small intestines were displaced upwards and to the right and carefully packed off with gauze pads. An incision was made along the parietal peritoneum to the left of the root of the meso-colon, and extending upwards nearly as far as the splenic flexure. By dissection, the sigmoid and its mesentery were separated from the iliac fossa and turned inwards. The ureter, which was attached to the mass, was carefully separated off and displaced backwards and inwards out of the way. When the bowel had been sufficiently freed it was turned back to the left, and the peritoneum covering the inferior mesenteric vessels was carefully incised close to the spine. The lymphatic vessels and glands were separated from the blood vessels by gauze dissection from above downwards. The splenic flexure was mobilised and the bowel and the mesentery were then clamped, and the diseased parts were isolated and removed, care being taken to preserve the continuity of the superior hæmorrhoidal vessels. The mesentery was tied and the rent in it was sewn up, the first layer passing through all the coats, the second including only the sero-muscular tissue. A small temporary drain was placed at the lower angle of the wound, which was elsewhere closed in layers in the usual way. To ensure absolute rest to the bowel very little but water was given by the mouth for three days, and morphine was injected subcutaneously to procure sleep on the first and second nights. No purgative was given by the mouth, and the bowels were allowed to open naturally with the aid of a small oil enema on the eighth day.

The patient made a good recovery, and left the private home a month after the operation. Dr. Woollett has kindly kept me informed of his further progress, which has been uninterrupted. I saw the patient on February 24th. He was looking very well, and had gained over 2 stone in weight. The writer saw him again in December, 1919. He had been doing his usual hard work without any inconvenience beyond a little "indigestion." He occasionally has to take an aloin pill.

Six and a-half inches of bowel were removed. Upon slitting it open along its free border no growth was seen. Something bulged in it at the mesenteric border. The mucous membrane was neither thickened nor ulcerated. Upon cleaving the mesentery many necrotic foci were seen, and several of these had broken down into small abscesses. A probe could be passed into several pouches extending into the mesentery from the mesenteric border of the bowel, and reaching quite near to some of the breaking-down areas. The necks of the pouches were quite narrow, so that they would be overlooked unless specially sought. None of the diverticula were visible on account of the thickness of the fat meso-colon. A piece of the diseased mesentery was sent to the Clinical Research Association for microscopic examination. The following report was returned:—

"This specimen is composed of fat and fibrous tissue with occasional nerve fibres. It is inflamed and shows marked leucocytic infiltration and endothelial proliferation, with a phagocytic giant cell here and there. We find no evidence of tubercle or of malignant growth."

CASE 3.—Male, 40. Operation 1910. Six months history Sharp pain in right groin. No fever except rigors in final stage. Diarrhœa three months before operation for tenesmus; no mucus or blood. Diagnosis—appendicitis; operation by another surgeon; appendicectomy and excision of mass in pelvic colon size of golf-ball; open ends brought to skin. May, 1914—Closure of artificial anus by the writer with difficulty; end-to-side union; patient very well ever since.

Report by Mr. Targett.—"Breaking down inflammatory focus which has involved and destroyed some of the muscular coat of the bowel. No evidence of any form of malignant disease. As to the cause of an inflammatory formation in such a position, one can only offer suggestions. Minute herniæ of the mucous membrane through the muscle coat are liable to form in the descending colon; these pouches retain fæcal matter and lead to inflammation and abscess." Patient was very well in January, 1920.

CASE 4.—Miss C. (sent by Dr. I. R. Cook), aged 60; subject to chronic constipation; seen in 1916. Twenty years ago—pelvic peritonitis. Pain in lower abdomen chiefly in right side, on and off ever since, but especially in the last seven years. Many attacks of pain in lower abdomen, mostly in left side, with definite tenderness above the left Poupart's ligament, and a temperature of about 101°. Bed, 3–4 days; generally well in a fortnight. 1914, appendicectomy; a swelling found on left side of pelvis on the pelvic colon, not connected with the fallopian tube or ovary. The attacks persisted; no blood or slime.

Operation, January, 1916. Omentum adherent to hard swelling in pelvic colon; many ad-

lesions to side of pelvis, fallopian tube, and left ovary, which were otherwise normal. Several diverticula containing hard calculi in the upper part of the pelvic colon and in iliac and descending colon, and one on posterior surface of the descending colon; but none in the lower part or in rectum. Several were removed from the peritoneal surface of the colon. The inflamed hard mass on the front and left side of pelvic colon was incised, thus opening two diverticula containing fæcal matter and pus. The pouches were removed, their necks tied and inverted. There was another inflamed hard area on the posterior wall of the descending colon which was not incised. The remainder of the colon and cæcum appeared to be normal. Resection was thought unnecessary. After-treatment by laxatives, especially liquid paraffin. She remained well for nearly a year, but since then she has had several milder attacks, but not severe enough to call for further operation; patient was well in January, 1920.

CASE 5.—Sent by Dr. Cane (Guy's Hospital GAZETTE, August 5th, 1911, page 327). J. K., man, aged 45, said his bowels had acted regularly every day all his life. He had had many attacks suggestive of appendicitis during the last six years. Came to see me on June 19th, 1911, when he was just recovering from the worst attack he had ever had. He said that he had a great deal of pain on defæcation and usually passed a little blood during the attack. He saw a surgeon four years ago who diagnosed cancer of the rectum with fistula into the bladder, and he advised against operation. He has since been to several hospitals, where, he says, the same diagnosis has been made. He wastes a great deal during the attacks, but he slowly picks up again. The patient looked anæmic and ill. The bowels act perfectly in the interval between the attacks.

The patient was admitted into Guy's Hospital, and examined with the bismuth and X-ray method without any further information. He was cystoscoped on July 14th, and the aperture in the bladder was found in the upper part of the posterior wall on the left side. Gas could be seen issuing from that neighbourhood. The aperture was indicated by a whitish prominence with a central dark crack. There was no sign of growth. Granulations were seen about the aperture. There was a considerable amount of cystitis. On sigmoidoscopy (the patient being in the perineal position) it was found to be impossible to introduce the instrument more than six inches, where the bowel was rigid, fixed, and somewhat contracted, but no ulceration could be seen. An attempt in the left lateral position gave no better result. Bimanual examination revealed a hard swelling on the left side of the pelvis at the brim. This was thought to be inflammatory. The patient was advised to have an operation, which he gladly consented to, saying that he would prefer an artificial anus to his present pain and misery. It was thought probable that an anastomosis might be made between the small intestine and the front wall of the rectum, or a resection of a part of the sigmoid if necessary, with an end anastomosis in the pelvis over a large rubber tube, with invagination.

Operation.—The abdomen was opened through the left rectus. A mass of adhesions could be seen in the pelvis, the small intestine being held down to the left side of the bladder. The Trendelenburg position was adopted, and a large pad and gauze roll were inserted to keep the small intestines out of the way. The adhesions were then separated by blunt dissection. In doing this, some fæcal matter was seen, and it was thought that the opening was probably in one of the coils of the small intestine, several of which showed necrotic areas which formed part of the wall of the branching abscess, amongst the coils. Several of these areas were invaginated by means of fine silk. Several loops of the small intestine were acutely kinked, and it was clear that the attacks of obstruction were due to inflammation of these with increased kinking. Their mesentery was shortened. Two necrotic areas were seen on the back wall of the bladder high up on the left, and several on the front and inner side of the descending loop of the sigmoid along the line of attachment of appendices epiploicæ. Through one of these a probe could be passed into the bowel. The perforation was invaginated with silk with some difficulty, and an appendix epiploica was used to reinforce the suture. No diverticula could be found, and the appendices were not larger than normal. The upper part of the sigmoid was normal. There was no obvious narrowing of the sigmoid at the site of the fistula. The opening was about seven inches from the anus, and well above the angle formed between the pelvic colon and the rectum. The peritoneum was invaginated over the opening into the bladder, with silk. The cæcum, which had been pushed away by the pad, was brought into the wound. The ap-

pendix was not inflamed, but an inch from its end there was a gap where a portion of it had clearly sloughed long ago, and it was thought probable that the patient's original attack was one of appendicitis, and that a residual abscess had formed towards the left side in the pelvis, and that it had burst both ways (into the bladder and into the sigmoid), and that from time to time a little leakage of fæcal matter occurred amongst the adhesions in that neighbourhood, setting up attacks of localised peritonitis. A tube containing a wick of gauze was left at the lower corner of the wound, which was otherwise closed in layers. The operation, which was a difficult one, lasted about an hour and a quarter. He died six days later.

At the post-mortem there was peritonitis in the lower half of the abdomen, some œdema of both lung bases, bronchitis, and early pericarditis. The hole in the bladder had healed, so that it could *not* be discovered on careful inspection and the use of a probe. The hole in the sigmoid had also healed. There were, however, a good many diverticula in the pelvic colon, which were not visible from without, but which could be easily found from within the lumen. Some of these were projecting into the appendices epiploicæ.

CASE 6.—*Diverticulitis of Pelvic Colon. Colico-vesical Fistula. Resection of Pelvic Colon.*—A lady, aged 55 (sent by Dr. Brenchley), had had a laparotomy—elsewhere—for a supposed gynæcological pelvic tumour six years ago. A mass, thought to be carcinoma, of the pelvic colon was then found and dropped back. The patient refused further operation and remained fairly well for six years. Early in 1920 pelvic inflammation with spurious diarrhœa and high fever developed. A pelvic abscess burst into the bladder causing cystitis. Gas, but no fæces, frequently passed through the urethra on micturition.

The patient became thin, anæmic and very weak. At the end of 80 days of severe symptoms the pelvic colon which was very thick and adherent was separated from the bladder, and a fistula on the posterior wall of the bladder was found and closed. Several pelvic abscesses were opened, and the pelvic colon was resected. It was impossible to join up the colon to the rectum; therefore, colostomy was performed. The patient is doing well, but it is too early to judge the result at present.

DIAGNOSIS.

Monsarrat,* and especially Moynihan† and Maxwell Telling,‡ have drawn attention to the mimicry of malignant disease by inflammatory stenosis of the sigmoid colon. It is very important to bear this in mind. The following points may suggest the innocent nature of the obstruction :—

1. The long duration of symptoms, especially the history of life-long constipation.

2. The absence of blood in the stools on repeated examination. In most cases the inflammation seems to be almost confined to the outer coats of the bowel, with the result that bleeding is unusual. The repeated presence of pus in the motions is important, especially in the absence of blood. In my cases the pain and tenesmusus were very severe, and I think more marked than in any case of malignant disease that I have ever seen. The slight degree of cachexia is said to be of value.

TREATMENT.

When chronic inflammation has led to stenosis of the colon, giving rise to chronic intestinal obstruction, palliative measures are not likely to afford permanent relief or cure. Laxatives and repeated enemata may make life tolerable for a time, but an operation becomes necessary eventually to save life. Therefore, it is wise to recommend this before the obstruction becomes complete or severe ; so that a radical operation may be hopefully undertaken and completed at one sitting.

CHOICE OF OPERATION.

So few cases have been fully recorded that it is difficult to say what is the best thing to do when a correct diagnosis has been made either before or at the operation. Dr. Telling has drawn attention to the fact that these patients are particularly susceptible to infection; peritonitis and suppuration of the abdominal wall have followed in a large proportion of cases. It is very important to prepare the patient carefully and to take every precaution against infection. The following operations may be briefly discussed : (a) colostomy ; (b) ileo-sigmoidoscopy; and (c) resection.

Brit. Med. Jour., vol. 2, 1907, page 65.

†*Brit. Med. Jour.*, vol. 2, 1907, page 1,381, and *Edinburgh Med. Jour.*, March, 1907.

‡*The Lancet*, March 21st and 28th, 1908.

(a) *Colostomy.*—This operation affords much relief without great risk to life, but an artificial anus has so many obvious disadvantages, as to make it undesirable for sensitive patients. As a temporary measure it may be tolerated when primary resection or short-circuiting is not safe or is impracticable at the time. It is particularly objectionable for the permanent treatment of patients who are not suffering from malignant disease, and may be expected to survive for many years. It is of the utmost importance to bear in mind that what appears to be an obvious malignant growth of the sigmoid colon may be only inflammatory. The mistake may be made even when the abdomen is opened. When operating for acute, following upon chronic intestinal obstruction, or when performing colostomy because a supposed growth is too adherent and extensive for removal, it may be useful to remove a small piece for microscopic examination. It must be remembered, however, that a good deal of inflamed tissue surrounds a growth, so that too much reliance must not be placed upon a negative report. Occasionally the rest and drainage afforded by the colostomy may lead to partial, or even to complete disappearance of the stricture, so that the artificial opening may be closed, but this is not very likely, for the diverticula remain and fibrous contraction is almost certain to continue. In other cases a temporary colostomy may be followed by secondary resection of the diseased part of the colon with the restoration of the continuity of the bowel.

(b) *Short-circuiting.*—It is unfortunate that the disease is usually in the part of the colon which is the most inconvenient for the anastomosis. Moreover, the anatomical relations are greatly altered by the disease. The meso-sigmoid is shortened and thickened and the disease may extend to the descending loop of the sigmoid or pelvic colon, so that it is almost impossible to make the anastomosis in healthy bowel below the disease. When the stenosis is high up, as, for instance, in the splenic flexure of descending colon, a short circuit can be easily performed, but without subsequent resection it is not likely to be permanently satisfactory, because the diseased segment causes symptoms for some years afterwards, and malignant disease may possibly supervene as indicated by Mayo.

(c) *Resection with End-to-end Union* appears to be the operation of choice for stricture of the colon, without extensive adhesions, for it offers a good chance of cure at one operation without undue immediate risk. It is necessary to prepare the patient carefully by dieting, aperients, and enemata before undertaking the operation.

In some cases immediate resection with drainage of the bowel above and below has been successfully done, Paul's tubes being tied into the two cut ends of the remaining colon. Another operation is generally necessary to re-establish the natural channel; although this may take place naturally by the sinking in of colostomy openings.

(d) *For Colico-vesical Fistula.*—When a fistula has developed between the colon and the bladder as a result of diverticulitis of the colon, and the diagnosis from malignant disease has been established by means of the cystoscope, the sigmoidoscope and the long and innocent course of the symptoms, an attempt may be made to cure this very troublesome condition by laparotomy. The cystoscope may reveal the absence of ulcerating projecting carcinoma at the site of the fistula, and the sigmoidoscope may reveal the site of adhesion, stricture, and perhaps of the fistula. If the lower six inches of the bowel can be proved to be healthy, an operation is hopeful. If the obstruction and fistula are lower the operation may be very difficult and dangerous.

Detachment of the colon from the bladder with closure of the openings into their viscera may be performed with the aid of the Trendelenburg position and a good light.

The opening into the bladder, unless the wall is rigid, is fairly easily closed and inverted and covered by the uterus or broad ligament, and if the disease in the bowel is fortunately localised, without stenosis and rigidity a similar plan may be adopted for it. But if the disease is extensive and causes a definite stricture, and especially if adhesions are dense and extensive preliminary colostomy with spur formation is indicated. This relieves the distressing pain and cystitis and improves the general condition of the patient. It also makes the subsequent resection of the diseased part of the bowel much safer. It is wise to make the colostomy only a little above the stricture, so that it can be removed and the channel of the bowel re-established at the second operation, and a third operation can be thus avoided.

Mountains and Mountaineering.

BY SIR GEORGE SAVAGE.

DEAR MR. EDITOR,

Naturally, I feel flattered by your request to give an account of my talk on mountains and mountaineering the other night at the Physical Society; but, as I then said, it was not a lecture, and I was only assuming the position of showman. I admit that I had a very fine collection of lantern slides, that were made by my late friend, Clinton Dent, of St. George's. I pointed out that I had at least two objects: one was to afford a certain amount of interest and pleasure to Guy's men, and the other was to constitute myself a propagandist, for, having myself derived so much benefit and pleasure from climbing in the "Playground of Europe," I wished to induce other Guy's men to follow my lead.

First, I pointed out the beauties, and also the dangers, of Swiss villages; their construction of wood leading to their rapid destruction if once a fire started in them. Next, being placed at the base of mountains, there are certain risks in connection with avalanches. There were some rather interesting photographs of chalets, and I pointed out the quaint habit there was in Switzerland of putting texts or epigrams on these chalets, and I gave examples of some. For instance, this was one:—

"There lives no man on this earth who builds so that he always pleases. Let man or woman come, still I have done my best."

Again:—

"There is no man in the world who can build so as to please everyone. If this does not please everyone, still I have done my best."

On the chalet, not infrequently, there are texts; and there was a strong and dominant feeling of superstition among mountaineers, associated with profound religious belief: texts referring to future Heavenly mansions constantly occurring. After the chalet, I pointed out, following the lines of Professor Tyndal, the beauties of the various forms of water. I exhibited photographs of clouds, showing the parallel between clouds in the air and waves on the sea. I referred to personal experiences when on the mountain top with a thunderstorm immediately below, and mentioned the supposed danger that occurs under those conditions, in consequence of the highly-charged electrical condition of the air.

Next to clouds, I spoke of water and waterfalls, and the dependence of Switzerland, to a great extent, on the motor power produced from water-falls. How, in fact, nearly every village was supplied with electric light, and telephones were everywhere, also how many railways were driven by electricity produced from water-falls. I showed, also, not only the water-falls, but the ice-falls, and the gradual development of glaciers from snow fields above, and the very marked difference between Summer and Winter in Switzerland in relationship to rivers: Summer producing a great increase in water and water-power; the cold in Winter, on the other hand, cutting off the water supply.

I recounted the history of the bridegroom who fell into a crevasse on one of the glaciers, and how, according to Ray Lankester, the bride, being informed that, sooner or later, the body would re-appear at the end of the glacier, visited this glacier year by year. At the end of some forty years it was reported that the body appeared again. I was obliged to take off the bloom of the story, because, although fragments of the body appeared, with things which enabled the body to be identified, there was wanting the romance of the aged widow seeing the youthful bridegroom appear unchanged at the end of the glacier.

It was pointed out that glaciers have all the characteristics of solid rivers, and the very marked effect they have upon the geological structures; how they carried down huge masses of rock from the highest parts of the mountains right into the valleys.

I then went on to refer to the requirements of a climber: the axe, the rope, and the sleeping-bag. I showed two or three slides of the imaginary demons which were supposed to frequent Switzerland in former times, and I referred to the supposition that these extraordinary figures really represented pre-historic animals, traditions with respect to whose existence had been carried on by word of mouth. I do not feel inclined to accept this.

Next, I pointed out two special varieties of mountains. Although, as I said, it is not absolutely possible to differentiate between a snow

mountain and a rock mountain, as nearly all mountains have, if high enough, both snow and rock. I was able to show photographs of men climbing, both over snow and over rock, and I referred to some individual difficulties one had experienced. Thus, making an ascent of the Gabelhorn from an untried side, we found ourselves within a hundred yards of the top, on a slope of rock that had a glaze of, perhaps, half an inch of ice over the whole surface. It was, therefore, essential that, most carefully, steps should be provided by clearing away the surface of ice. This, as I mentioned, associated with a cold northerly wind blowing, occupied some three quarters of an hour, and by the time we reached the top, I was not in a position to rejoice, as I dreaded the possibility of having to return by the way we had gone up. Fortunately, however, we had not to do this.

I pointed out that I had climbed with guides for many years, and had gone through an apprenticeship, learning the various arts and crafts of mountaineering. After a time, a certain number of us, including Sir Frederick Taylor, joined together and climbed without guides. Some experiences were much more interesting than being led by skilled and accomplished guides; they were associated with extra trial and risk. On one occasion we were out for 32 hours, the night being spent on rocks, and I, being the heaviest, was tied on one side of the rock, and I counterbalanced, or was a counterpoise to, my two companions on the other side. The chief interest, to me, of that night was that there was only one position in which I could get any change, and that was by putting my foot on to a ledge of rock opposite to me. But the instant I lost consciousness, even for a second, my foot fell down. Yet during that interval of a second or so I had a very detailed dream, merely confirming the knowledge that dreams very frequently are instantaneous mental productions. Another occasion on which, with Sir Frederick Taylor, I was climbing left an experience that I shall never forget, and which sometimes in the night appears as a nightmare. We determined to make an ascent of the Nesthorn, though the guide said there was too much snow and ice, and that we should not be able to do it. Nevertheless, everything went on quite satisfactorily for a considerable time, till at last we came to a steep snow slope. But the snow, fortunately, was hard and crisp, and it was a pure delight walking along this steep incline. I may say it was unusually steep, and one was looking down a slope of 1,000 or 1,500 feet below one. Gradually the snow encountered was harder, and it became necessary to cut steps. I was leading, and Taylor and my other companion kept on impressing upon me the importance of being steady and of making deep steps. Gradually the ice got harder, and so brittle and chippy that one had considerable difficulty in cutting out firm foot-holds, and it became even necessary to cut hand-holes at the same time. This process I had to continue for the better part of an hour. My hands first blistered, then the blisters broke, and the strain of the last few yards will never be forgotten. Of course, it was somewhat unsatisfactory when we got to the top to find that it was quite an unnecessary journey to have made, that we could have done it much more readily without crossing the snow face. Still, with all the dangers and all the excitement, memories of the mountains still cling very closely to one.

I finished off, as I not infrequently do in these talks, with a description of the first ascent of the Matterhorn, which was made by my late friend, Charles Whymper. The Matterhorn has been looked upon as the Mecca of climbers. Formerly it was, but now-a-days what with improved approaches, chains, ropes, and one thing and another, it is a mountain promenade rather than a dangerous climb. In the original climb, Whymper and others had tried to make the ascent from the Italian side, but had failed. Whymper had resolved to make one trial more there, and had engaged guides, but, to his disgust, when he went over to carry out his expedition, he found that these guides had thrown him over and had joined an Italian party. He went back to Zermatt determining that, anyway, he would make an attempt from the Swiss side of the mountain. He took a very fine guide, probably one of the finest in Switzerland, a man named Croz, besides whom he had Peter Taugwalder. He took with him, unfortunately, too large a party, including an inexperienced Harrow boy. At all events, they reached the top with greater ease than they expected to, and felt so buoyant that they were inclined to play a practical joke. Looking down on to the Italian side, they saw a party of Italians with, probably, their defaulting guides, climbing steadily up. They therefore trundled small stones down upon them, and as for generations

there had been a belief that the Matterhorn could never be climbed because there were little devils at the top whose one function was to guard the virginity of the mountain, when these stones began to roll down upon the Italian guides they at once exclaimed that they were going no further, that it was very evident that the top was guarded by devils. After this Whymper's party decided to descend, and when they got to a somewhat difficult angle, overlooking a precipice of, probably, some 2,000 feet, the leading guide turned round to the next on the rope, who was the young Harrow boy, and requested him to be very careful and steady. This was, undoubtedly, a very unwise precaution, for such a warning was just enough to make the lad self-conscious. At all events, what happened was, that he lost his footing, fell on the leading guide, who was a very heavy man; this dragged the next two men over the edge of the precipice, when the rope broke, and Whymper and the other guides were left behind. At one time there was a suspicion that the rope might have been tampered with, but one has seen the rope end oneself, and one is perfectly certain it was an accident pure and simple.

The Matterhorn, then, is the end of my talk, and I would merely finish to-day with a quotation from Whymper, whose book on the Matterhorn is the standard authority :—

"There have been joys too great to be described in words, and there have been griefs upon which I have not dared to dwell; and, with these in mind, I say, 'Climb if you will, but remember that courage and strength are nought without prudence, and that a momentary negligence may destroy the happiness of a lifetime. Do nothing in haste, look well to each step, and, from the beginning, think what the end may be.'"

Reviews.

The Sympathetic Nervous System in Disease. By Langdon Brown. (Oxford Medical Publications. Henry Frowde, Oxford University Press); price 10s. 6d.

Those who had the pleasure of hearing or reading Dr. Langdon Brown's Croonian Lectures for 1918 will welcome the appearance of the present volume, which embodies in expanded form the substance of those lectures. For many, too, who must feel, with the reviewer, that their education in respect of the physiology of the sympathetic system was neglected or at the best "sketchy" and inexplicit, the summary of evidences and suggestive views contained in the book will prove most helpful and inspiring. A good disciple of Gaskell, the great English pioneer in work on the Involuntary Nervous System, Langdon Brown has himself done service in latter years in obtaining a wider recognition of the importance of this work, and, in particular, in studying its relations to various disease states. The first chapter deals briefly and clearly with the known anatomy and physiology of the subject, and thereafter the author proceeds to discuss the inter-relationships of the endocrine glands and the autonomic system, always supporting his theme by appropriate clinical references; the theories of glycosuria are in this connection reviewed in the light of recent knowledge and researches. The chapter concerned with "The Sympathetic Nervous System and Diseases of Digestion" is especially worth perusal, and can scarcely fail to initiate fruitful trains of thought and perhaps new lines for investigation. The long-recognised inter-play between the emotions and the digestive functions, the irritative phenomena of which hyperchlorhydria and ulcer secondary to a chronic appendicitis is the best example, and certain other dyspeptic events are here given a neuro-secretory or neuro-muscular basis which must ultimately help both in the diagnosis and treatment of conditions formerly regarded as being due to primary visceral disease. The much-disputed subject of "Shock," and the various circulatory responses are considered broadly, and throughout the book the antagonistic actions of the sympathetic and of the para-sympathetic (represented by the vagus and the sacral nerves) is emphasised and adduced to illuminate phenomena familiar in themselves, but which, before Gaskell, were not susceptible of clear interpretation. The arrangement of the book is good, and the author has on the whole resisted the temptation to make excursions into fields of speculation. In a subject so complex we have still to content ourselves largely with theory, and while the book does not claim to have attained to the pitch of accurate proof in any of its wider contentions, it cannot be denied that it points a way for the physiologist and clinician in several of their more perplexing problems.

The Principles of Ante-Natal and Post-Natal Child Physiology, Pure and Applied. By Dr. W. M. Feldman. (Messrs. Longmans & Co.); price 30s. net.

Dr. W. M. Feldman in this book has collected within the compass of some 700 pages detailed references to almost all the recent work of investigators on the Continent, in the United States, and in this country. This is in itself no mean achievement. It has not been done before, and it has here been done supremely well. There are references to over 2,000 papers upon the subjects concerned, and in presenting all this material the great scope of the subject is revealed, the work that has been done is appraised, the lines for future research become clearer, and its immense possibilities are made evident. The book is, of course, a compilation, but the order in which it is set out is so logical, and each part fits so well into the whole, that the interest never flags. Reviews, like testimonials, are apt to deal freely in conventional terms of praise. For Dr. Feldman's book we do not think we can

express our admiration too strongly. Work in maternity and infant welfare is, or ought to be, based upon physiological knowledge. In work of this sort a new and special branch of medicine is emerging. It was time that its physiological basis should be set out clearly, and there is perhaps no subject of like importance at the present time which stood in greater need of such a service. On all sides contrary opinions on matters of fundamental importance are set forth with authority. Never was such a jumble of contradictions, with so little that is accepted as final and beyond dispute. In this country physiological studies have long held a foremost place, and though it is to be deplored that the special branch of infant physiology has not as yet attracted the continued attention of any first-rate investigator, nevertheless a great part of the work of Leonard Hill, Haldane, Pembrey, Starling, Keith, and many others, is applicable. The German literature is enormous, the American rapidly increasing and of very high quality. With all this Dr. Feldman is in familiar touch. Biology, electrocardiography, the dynamics of the skeleton, dietetics, bacteriology—no subject comes amiss to him, and of all he writes convincingly and interestingly. We cannot but admire the skill with which he has extracted from so many branches of learning all that is of value to the student of infancy, and the insight with which he makes clear its practical application. To the work of maternity and child welfare he has done a real service, all the more gratifying because to us at least somewhat unexpected. He has done for ante-natal and post-natal physiology what Hall has done for a later age in his "Adolescence." Dr. Feldman will pardon us for saying that till we had read his book we should not have known to whom to look for a work of this sort.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—My son entered the wards a short time ago. He tells me that he is often working in the Surgery from 9.30 a.m. until seven o'clock at night doing dressings and what not. On the days when he is on duty he returns home utterly tired out. It seems to me that it would be far better to put a dresser on duty twice a week for four or five hours instead of for nine hours at a stretch.—I am, yours faithfully,

MATER FAMILIAS.

PREVENTION OF VENEREAL DISEASE.

DEAR SIR,—I read with interest "suggestions for control of venereal disease by the State," emanating from the Medical Woman's Federation, published in the journal of the 21st February.

I think that all medical men or rather practitioners agree as to the necessity of teaching morality in sexual matters, but surely we cannot rely upon that alone. Nature never intended humans to be continent, rather the reverse. The fear of venereal infection has never yet deterred the virile man from taking the risk when under the influence of passion, and, further, the preaching of continency by married men to single men who are not in a position to marry rather upsets the old school-book axiom that "example teaches better than precept." We preach prophylaxis in every other branch of medicine; why not in venereal disease?

During the war I was in charge of Blue Light Depot, and lectured to garrison troops on venereal disease. Nearly 900 men used the depot, and not one contracted the disease. I may mention that I was in charge of morning sick, so that I had an opportunity of questioning cases of venereal disease as to whether the convenience had been used or not, and this in the Cape Peninsular where venereal disease is rife.

The argument that the treatment is not certain, breeds false security and encourages promiscuous intercourse is met by the fact that no lecturer, as far as I know, informs his audience that the treatment *is* certain. He says, which is true, that it greatly decreases the chance of contracting disease if used quickly after the risk has been taken.

Again, the fact that *the treatment is not certain* would have a deterrent effect upon the timid individual, who is evidently the class of person the Federation fear would be drawn into immoral practices. On the other hand, every case of venereal disease avoided, means possibly the saving of innocent women and children.

Let us as medical practitioners be true to our profession and give every one a chance of avoiding disease, whether it be venereal or otherwise. That moral teaching by the Church, &c., has been a failure in preventing venereal disease is patent. It is up to the medical profession to use any treatment that will prevent rather than cure the scourge in our midst, which has been camouflaged long enough. The argument that the treatment may be abused may be carried further. People take drugs to excess, but no one would think of giving up morphia in medicine because there are morphia maniacs.

In conclusion, there are thousands of young men who have been continent for years, but one day or night nature asserts itself, and before they recover their mental balance the risk has been taken. Are we to refuse them the chance of avoiding the possible results of their lapse?—Yours, etc.,

H. KNIGHT-RAYSON, M.D., M.R.C.S., L.R.C.P.
Late Capt., R.A.M.C.

"Knightsmead,"
Bayville Cp., South Africa.
March 23rd, 1920.

DEAR SIR,—The notice of the appointment of a number of surgical ward clerks in your issue of the 17th inst. may presumably be taken to indicate that the alternative scheme for a preliminary three months' course in the various branches of pathology and elementary clinical methods has been dropped and the old arrangement reverted to. This is now no business of mine, but perhaps, as one who was for ten years in some small way responsible for the teaching in the microscopical pathology class, I may be allowed to shed one tear in your columns over the frustrated attempt to improve the conditions under which that teaching was given.

I was lucky enough to be ward clerk to Mr. Jacobson when Mr. Thompson was registrar, and I think that none could have worked under more favourable conditions or appreciated more fully the value of the appointment; moreover, Dr. Pembrey will certify me any day as a Tory of the most crusted variety, and whether or no I am indeed as blue as he might paint me, I am at least not likely to be over-eager in advocating any drastic change in an appointment that has proved its worth so fully through the test of many years. But there is another side to the question, although you, Sir, in your editorial comment seem very deliberately to avoid it. To many the matter may seem one of comparatively little consequence, but if viewed in its right perspective I think it will be found to be a pawn of no small importance in a struggle between two great Guy's traditions, the clinical and the pathological.

Pathology has made great strides in the past twenty years, and recognition has been given to this fact in the appointment of special teachers and the building of new laboratories; but has our mental attitude kept up at quite its proper pace? When we turn to the arrangements made for that important person, the medical student, we find that he is still much where he was. He still goes (or does not go) at odd times to a more or less disconnected series of classes in bacteriology, morbid histology and chemical pathology—a hap-hazard system that might well have been specially devised if we had wished to give the impression that these were classes of a rather unimportant nature that must nevertheless be squeezed in somewhere. The new scheme (now apparently abandoned) whatever its failings, was an attempt to enable your teachers in pathology to treat their various branches as one connected organic whole—to give the men a comprehensive picture of the main principles of pathology, and so to complete the solid foundation laid during the earlier years, without which no clinical observation, however accurate, can produce its full result. Apart from the mere educational question, this sudden reversal of policy and the manner of its happening has its distressing side in its more general aspect, for one can but see in it a refusal, possibly blind but none the less emphatic, to pay to pathology the honour that in the past was so royally won and so freely given.

Guy's has been in the past pre-eminent as a pathological school, but the time has gone by when she can remain so merely by continuing the outworn custom of appointing assistant physicians as demonstrators of morbid anatomy. Morbid anatomy is no longer the only or even the main avenue of advance in pathology, and if Guy's is to maintain her old tradition she must pay to pathology as a whole that same reverent devotion that she gave to morbid anatomy in the past.—I am, yours faithfully,

GORDON W. GOODHART.

24, Warwick Gardens,
Kensington,
April 24th, 1920.

SIR,—In your issue of today's date "A Guy's Nurse doing Maternity Work" attributes a certain statement to me. I regret that she read my lecture with so little interest as to digest it inaccurately. The abstract in the GAZETTE of the 3rd reads as follows:—

"One of my correspondents writes as follows: 'I am setting forth the impressions that I have gained. . . . The greatest advocates seem to be the nurse, who, of course, gets an extra fee . .'"

I have no knowledge which should guide me to express any opinion upon the point at issue, *i.e.*, that the nurse advocates circumcision, but if my correspondent is right in his facts I very much doubt whether the reason is correct, for I am told that as a rule the nurse is expected to include her duties in connection with the operation in her ordinary maternity fee. In lieu of an apology for attributing to me opinions which I have not expressed, I shall be glad to receive from "A.G.N.D.M.W." hints as to the dressing and after-care of circums.

Another old Guy's nurse doing maternity work wrote to me privately making the same charge against me. I replied denying the soft impeachment, and in answer to me she wrote as follows:—

"Before the baby is born most of the mothers say 'if it is a boy I want it circumcised,' and when one asks them why they have no answer to give except that they have known of some small boy about 5 or over who has needed to be circumcised and has been caused great pain thereby. They look upon it as they do upon vaccination, a thing to be got over early. If the mother doesn't know anything about circumcision, the father wants it done, and if neither have thought about it the doctor advises it, and so the operation is done after all. When a child of 2 or so has to be circumcised

I have often heard the parents say 'why didn't the monthly nurse say it needed doing,' and they think that she was very stupid. The doctor of one case had just had a bleeder that died, but he still thought it was necessary for the next one to be done in the same way. Most of the doctors in private work have different dressings, but Hazeline cream in a tube seems a favourite one, applied on a small piece of gauze and then wool, changed morning and evening at bath time."

I must admit that I haven't her permission to send you the above, but shall hope to be forgiven, as I feel that maternity nurses can teach us so many things about such cases that we ought to know.

I do wish some of your correspondents would inform me *why* universal circumcision is advocated by the nurse, parents, doctor, or anyone else, for if I am wrong in my views I should like to be told why.—Yours, etc.,

C. H. FAGGE.

3, Devonshire Place,
Portland Place, W.
April 17th, 1920.

DEAR SIR,—It has been found impossible to hold the annual concert of the Guy's Hospital Musical Society this year, and we must, therefore, ask you to contradict the notice announcing the concert which you kindly inserted in the GAZETTE last week. The reason for the inability of the Society to give a concert has been the poor attendance, especially of nurses, at the rehearsals. The nurses themselves are in no way to be blamed. A combination of lectures, with the other multitudinous duties which devolve upon them, has deprived them of the spare time which, in pre-war days, they were enabled to devote to the Society. We are sure your readers will agree that it is a pity that the time of the nurses should be so occupied that they are unable to take their share in the activities of the Musical Society.—We are, yours truly,

MAURICE E. SHAW,
CHARLES E. GALLAGHER,
Hon. Secs.

Guy's Hospital Chapel.

Annual Report.

The Rev. W. Waller did temporary duty after Mr. Charlesworth's departure, from January 13th to August 11th, 1919.

The Rev. A. E. Popham, a former chaplain, carried on the duties temporarily until a new chaplain was appointed.

During that time he worked exceedingly hard; whilst being very grateful for his valuable help, the Hospital was sorry to lose his services.

In October the Governors appointed the Rev. H. J. Hawkins as chaplain, and he took over the duties from Mr. Popham on November 11th, 1919.

In May, 1919, H. St. J. Bradford, of the Royal College of Music, was appointed organist. Much credit is due to him for the efficient way the musical part of the services are carried out. There have been many changes in the chapel workers during the year. Sister Hilda, after having done excellent work as sacristan, relinquished her post in May, 1919. Sister Lorna was appointed in her place. Nurse Playle left during the year, so Nurses West and Lane undertook the cleaning of the brass of the big lectern. Nurse Kier, senior, found she was unable to clean the brass of the small lectern, so Nurses W. Johnson and Cornwall clean it between them. Nurse Bailey is most helpful in fetching the wafer bread from the Sisters of Bethany.

The Chapel Committee thankfully acknowledge the gift of a beautiful white burse and veil given and made by Nurse D. Graham, who has now left, also a gift from a "grateful patient" of a wafer box and lavabo dish.

The Chapel Fund bought a new green frontal, which was much needed, for £21. Miss Huggitt's sister worked it very beautifully.

The Chapel Committee desire to thank all the workers in the Chapel for their help—not forgetting those who help to decorate on festivals.

During Advent we were fortunate in securing as special preachers Bishop Hook, Canons Craig and Woodward. On Ash Wednesday the present Bishop of Southwark paid his first visit to the Hospital and preached at a special service. The Bishop hoped to make this an annual fixture.

The Rev. P. D. Hedges, of Christ Church, Clapham, preached a very helpful course of Lenten sermons.

The Rev. A. C. Popham helped with the celebrations of Holy Communion on Christmas Day and throughout the octave by giving Holy Communion in the Wards.

The Rev. S. Groves, domestic chaplain to the Bishop of Southwark, gave most valuable help with the celebrations of Holy Communion on Easter Day. Also our thanks are due to him for visiting two wards twice a week for the past two months.

The Rev. H. Embling after Easter offered to help the Chaplain temporarily by being entirely responsible for two wards. This help is much appreciated and very welcome. The Committee would be lacking in gratitude did they not most gratefully acknowledge the help of the priests of the College of St. Saviour given so frequently in the celebrations of Holy Communion, and in cases of emergency, when the Chaplain is not in the Hospital.

Chapel Fund Account.

Statement of Receipts and Payments for the year ended December 31st, 1919.

Receipts.

1919.				£	s.	d.
Jan. 1.	To Balance brought forward from 1918 account			38	19	6
Dec. 31.	To Offertories, etc.:					
	Chapel	47	15 2			
	Bright Ward	7	15 8			
	Boxes, etc.	2	13 1			
				58	3	11
				£97	3	5

Payments.

1919.				£	s.	d.
Dec. 31.	By General Account:					
	Floral Decorations, etc. ...	6	6 6			
	Books, Printing, Music, etc.	2	4 0			
	Furnishing & Sundry Expenses	11	9 5			
				19	19	11
	By Special Offertories:					
	Met. Hospital Sunday Fund	3	8 0			
	S. London Church Fund ...	6	13 9			
	Maternity Samaritan Fund	8	2 6			
				18	4	3
				38	4	2
	By Balance Carried Forward:					
	Cash at Bankers			58	19	3
				£97	3	5

Audited and found correct,
W. J. CURRY.
January 22nd. 1920.

Change of Address.

S. W. Bevis, 196. Selhurst Road. South Norwood. S.E.25.

G. F. H. Bloom (Capt.), Central Flying School, Upavon, Wilts.

Frank E. Cave, Tisbury, Tower Road West, St. Leonards-on-Sea.

W. J. Dobson Smyth. M.A., M.R.C.S., L.R.C.P., Chalgrove, Exmouth.

H. T. Dupree, 1. Higher Summerlands, Exeter (Tel. 557).

G. Dunderdale, M.D., B.S., 280. Loop Street. Pietermaritzburg, Natal, South Africa.

S. Herbert, 3, Valley Drive, Harrogate.

E. G. Slesinger, O.B.E., M.S., F.R.C.S., to 2, Devonshire Place, W. ('Phone. Padd. 49).

W. P. Vicary, Surg.-Lieut. R.N., c/o Admiralty, Whitehall, S.W.

W. A. Young, 33, Weymouth Street, W.

C. R. Nicholson, Headquarters, Ministry of Pensions, Stoney Street, Nottingham.

Notes on Certain Types of Mastoid Osteitis.

By Mr. A. M. ZAMORA, M.S., F.R.C.S.

I.—Subacute Mastoid Infections.

Cases illustrating the importance of a Profuse Otorrhœa in Diagnosis.

The difficulties which beset the busy dresser in the Surgery when there is a question of deciding the gravity of an acute ear case are notorious and have been dealt with very exhaustively in a recent lecture by Mr. Layton.

The following are notes of three cases taken from a fairly large group which illustrate a very important type of mastoid osteitis which is not generally recognised, but which is frequently met with and ought certainly to be kept constantly in mind.

(a) B.F., æt. 10, came to Mr. Mollison's Outpatients on account of deafness and right otorrhœa. There was no pain and no pyrexia—and the boy felt perfectly well. On examination a large amount of stringy mucus was found to be passing out through a small anterior perforation, and the posterior part of the membrana tensa was seen to be bulging, though not red. There was no pain on pressure over the mastoid process, and no swelling nor redness.

The tonsils had been efficiently enucleated, but there were some masses of adenoids in Rosenmüller's fossæ.

On account of the persistent copious discharge of mucus and the continued bulging of the membrane it was decided to treat this case by removal of the adenoid remnants and incising the membrane to allow free drainage—in addition to the ordinary antiseptic treatment. This incision allowed much mucus to escape for a few days, but closed later and the condition recurred. A second myringotomy was done with precisely similar results. It was therefore obvious that it was impossible to drain the middle ear adequately by these means, and it was decided to drain it from behind by opening the mastoid antrum.

At the operation the mastoid antrum and cells were found to be filled with stringy mucus. An ordinary Schwartze operation was performed, and the boy recovered excellently.

This is an exceedingly rare condition, but one which has been definitely recognised by Lake.

(b) R.C., æt. 6, gave history of tonsillitis three weeks before attending the Hospital. This throat infection was followed by acute earache three or four days later, and then he developed otorrhœa on the right side.

On examination there was no swelling nor redness over the mastoid process, and tenderness was so slight as to make it doubtful whether it existed at all. The temperature was 98·4, but the mother volunteered the statement that the pulse had been persistently quick. The otorrhœa was profuse.

The boy was seen on three consecutive days, and on the third day it was decided to open the mastoid because (1) the copious otorrhœa persisted, and (2) the boy was beginning to look ill. No other change had taken place.

At the operation the first cut into the bone revealed pus, which was found to permeate the whole of the mastoid process. The most interesting point about this case was the relative absence of tenderenss in spite of the fact that the cortex of the mastoid was already involved in the necrosis. It is common knowledge that tenderness may be absent in cases of deep-seated suppuration.

(c) E.J., æt. —, attended Mr. Mollison's Out-Patients for chronic otorrhœa. Contrary to the usual custom, she was advised to have vaccine treatment. Some days after the beginning of her treatment by vaccines she came to Out-Patients for inspection. No complaint whatever was made by the patient, but Mr. Mollison was struck by the unusually abundant discharge, and made a more detailed examination, which revealed a slight tenderness over the mastoid process. There was no redness and no swelling. It was decided to open the mastoid, and at the operation a large area of necrosed bone was found, and there was actually an extradural abscess with extensive granulations on the lateral sinus. The patient is recovering well.

The observation to be made on these cases is that there is every conceivable degree of virulence in infections of the mastoid bone, and that it is of the utmost importance to recognise a condition of subacute mastoid osteitis which differs very widely from the usual description of the acute infections. It is this class of case which is often responsible for extensive and irreparable damage to the hearing apparatus and for serious intracranial complications, since owing to failure of detection, the destructive processes are allowed to extend widely.

It is difficult to describe a clinical picture for these cases since there are so many varieties, but a fairly representative case is as follows: The patient, whose general appearance gives one the impression that he is more seriously ill than he imagines, gives a history of acute otitis, one, two or even three weeks previously and since then there has been persistent and really copious otorrhœa with, possibly, continued earache deafness and malaise. Frequently when it is possible to take temperatures it is found that there is a slight evening rise, and the pulse rate is often quick. On examination the membrane is found to be red and œdematous and there is generally a small perforation situated in a position unfavourable for drainage, but these cases occur with even large perforations. The postero-superior wall of the deep part of the meatus may be sagging down slightly.

There may not be any swelling or redness over the mastoid process, and some tenderness is usually, though not always, to be made out. The presence of definite tenderness is of great help in diagnosis, but one of the difficulties of these subacute cases is that the tenderness is often slight and may be easily missed.

A very careful comparison of the two sides is essential, and in trying to elicit tenderness it is important to bear in mind that there is a fairly constant disposition of the cells, and infection tends to travel along definite lines, localising the site of tenderness:—

(a) Towards the tip along a line of cells which is best marked just behind the posterior meatal wall and leads to the larger apical cells which tend to tail off around the lateral sinus and may completely surround this structure on its superficial aspect, and when infected give rise to symptoms which simulate sinus thrombosis.

(b) Backwards into the process of bone separating the middle from the posterior fossa.

(c) Forwards involving the outer wall of the attic and the root of the zygoma and occasionally giving rise to œdema of the eyelids.

The most superficially placed of these cells are at the tip of the mastoid process, over the sinus and in the region of Macewen's triangle, and hence at these three spots tenderness is apt to be most marked.

It is the object of these notes to point out the necessity of recognising that in certain patients the relative lack of reaction to infective processes in the mastoid, causes them to develop a dangerous condition which is often left too long undiagnosed, but which should be more easily detected if special importance is attached to cases in which there is profuse and persistent otorrhœa. By this means, it is submitted, many cases subsequently developing the classical signs of the text-book, which are undoubtedly the result of undue delay in diagnosis, may come to operation earlier and be saved from unnecessary extension of necrotic processes.

It is in no way intended to contend that profuse otorrhœa is a constant sign of mastoid infection, but merely to point out its importance when it does occur.

My thanks are due to Mr. Mollison for permission to treat and publish these cases.

Report upon the Students' Club Library.

1. *Catalogue.*—All the books in the Students' Club Library have been catalogued on the card index system, and arranged in a cabinet in the College Reading Room.

2. *Circulation.*—Although enquiries have been made respecting the borrowing of Library books, few students have taken advantage of the facilities offered. It is pointed out that this Library is run in connection with Mudies, and the latest fiction is always procurable.

3. *Presentations.*—There has been very little response to the appeal for works of fiction, novels, &c., and it is hoped that as many Guy's men as possible will forward any books they have available. All presentations will be much appreciated, and should be sent direct to the Librarian.

4. *Periodicals.*—About 25 periodicals are taken regularly for the Library, all of which are kept in serviceable leather covers.

New additions include the *Field, Illustrated Sporting and Dramatic News, English Review*, and *Fortnightly Review.*

The daily papers include the *Times, Telegraph, Chronicle* and *Sportsman*, and are kept on special newspaper racks.

An appeal is made to all students to see that the periodicals are replaced on the racks and not taken from the Reading Room.

5. *Reference Books.*—The following books have been added, and are now available for reference purposes only:—P.O. Directory, Whittaker's Almanac, Pears Almanac, A.B.C. Time Table, Who's Who, and Burdett's Hospitals and Charities.

6. *Miscellaneous.*—Efforts have been made to secure better lighting arrangements, and on two occasions this year, sets of Osram lamps have been installed, and removed by somebody unknown.

New periodical racks have also been erected to accommodate the new magazines.

J. H. E. WINSTON,
Librarian.

Guy's Hospital Annual Dance.

When the suggestion to hold this year's Annual Dance was put forward, there was a feeling that it would not be advisable to do so, the reason being that last year's dance was said not to have been a success. It is only fair to deny this, and to remind all, that £70 was handed over to the Guy's War Memorial.

The Dance this year was held at Princes' Galleries, Piccadilly, on Wednesday, April 21st. Owing entirely to the unfailing efforts of the committee in selling tickets and assisting the Hon. Secs. generally, everyone without exception proclaimed the dance a huge success. One's only regret is that so few members of the Staff or their wives were present.

Those present included Dr. and Mrs. Hurst, Mr. and Mrs. Mollison, Mrs. Rowlands, Mrs. and Miss Fagge, Dr. and Mrs. Hunt, Dr. and Mrs. Mutch, Mr. Turner, and Mr. and Mrs. Slesinger.

The opportunity is also taken of praising the efforts of Mr. Maurice Stratum and his orchestra. They not only played most beautifully, but they did this without showing any signs of exhaustion, and were always willing to give encores. In fact, the success of the evening was in no little way due to them. A word of thanks is also due to the management of "Princes'" for the way in which they served supper—the supper itself was most excellent. It was a pity that, owing to the "early closing hours," it was necessary to have it so early.

In conclusion, one hopes that next year it will not be said "Last year's dance was a failure"—for if praise is worth anything then all we can say is it must have been a great success, and the balance on the *right* side is in the neighbourhood of £40.

Reviews, etc.

Essentials of Surface Anatomy. By Charles R. Whittaker, F.R.C.S. (Ed.), F.R.S.E. (Messrs. J. & A. Churchill) 8vo., pp. 80, Price 7s. 6d. net.

In this, the third edition of Mr. Whittaker's book, the surface markings of the various viscera, blood vessels, nerves and other structures are set down with clearness and accuracy. Taking into consideration the subject of the book, the author's treatment of what at best can only be in the nature of a verbal chart, is very interesting. The diagrams included are clear and adequate, and the text—tidings of joy—uses the old terminology throughout. There are few criticisms to be levelled against the

work. The references to the anterior branch of the middle meningial are rather insufficient. Thus on page 30 we are told that the lower two-thirds of the line MN (in Fig. 10) represents the artery in question. On page 31 we find that the bloodvessel passes a point 1½ inches behind the external angular process and 1¼ inches above Reid's baseline. These were all the references that we noticed, and we think that the middle meningial artery is worthy of a more complete treatment than it receives. On page 56 there is rather a good list of the structures opposite the various vertebral spines—a sort of panorama of the body, which starts at the attachment of the soft palate and ends with the lower limit of the spinal meninges. This list, however, leaves out one or two important points such as the surface markings of the lower end of the spinal cord. However, there can be no doubt that this manual of surface anatomy will repay the student who reads it, whether he does so in order to pass his examinations or in the less sordid pursuit of knowledge for its own sake.

Principles of Human Physiology. By Ernest H. Starling, C.M.G., F.R.S. (Messrs. J. & A. Churchill) 3rd edition, 1920; price 25s. net.

We must welcome a new edition of Professor Starling's well-known text-book. In this edition, the various advances that have been made in physiological knowledge during the war have been incorporated, while the section on the sense organs has been revised and largely re-written by Dr. Hartridge, who is entirely responsible for the section on vision, which is quite new. The book has been slightly increased in size on this account, although other parts of the work have been abbreviated. The whole subject matter is very fully and lucidly dealt with, especially the sections dealing with metabolism, renal excretion, and the formation of lymph, to which latter, of course, Professor Starling himself has made very notable contributions by his experimental work. The new work on the importance of the accessory food substances receives adequate mention. Though the book with its thirteen hundred pages crammed full of facts tends to be rather large for the average student working for his second examination, it is undoubtedly indispensable to him as the best modern English text-book on Physiology. But perhaps the newly qualified man, with more leisure and more peace of mind than is possible for the student with examinations looming before him, will find here that sure footing of facts and the inspiring stimulus necessary for anyone who hopes to help in any way the advance of medical science.

Athletic Sports.

The Annual Athletic Sports are to be revived this year, on May 29th, at Honor Oak Park. Six years have passed since they were last held, on which occasion entries were poor and the attendance small. These were the usual conditions under which the pre-war Hospital Sports were held, and consequently we have not held the Inter-Hospital Sports Shield since 1895. This year we look to the entire Hospital to help in bringing back the shield to its rightful home, and *this can only be done if everybody who can* turns out fit and trained at our own sports. Lists of events are posted in various parts of the Hospital, and training can be commenced right away at Honor Oak Park. Members of Guy's Hospital are also invited to train from the South London Harriers private room at Stamford Bridge Track, where there are hot baths and a masseur. They will be under no obligation to join that Club. As a trial run, it is suggested that as many men as possible should enter for the London University's sports at Herne Hill on May 26th, notices of which are posted in the Hospital.

Papers by Guy's Men.

F. J. Steward, M.S., F.R.C.S., A Clinical Lecture on the Treatment of Septic Peritonitis. *B.M.J.*, April 17th, 1920.

T. D. Lister, C.B.E., M.D., B.S., M.R.C.P., F.R.C.S., Medical Problems of Life Insurance. *Lancet*, April 17th, 1920.

H. W. Barber, M.D., M.R.C.P., A Case of Recurrent Ulceration of the Skin caused by a Diphtheroid Bacillus.

R. P. Rowlands, O.B.E., M.S., F.R.C.S., (1) Two cases of Cirsoid Aneurysm; (2) Case of Dislocation of the Patella. Proc. Roy. Soc. Med., March, 1920, vol. xiii., Clinical Sect., page 26.

H. W. Barber, M.D., M.R.C.P., Case of apparent Diphtheroid Infection of the Skin. *Ibid.*, Sect. of Dermat., page 40.

Herbert Charles Cameron, M.D., F.R.C.P., A Presidential Address on Maternity and Child Welfare Work; delivered at the first meeting of the Society of Medical Officers of Maternity and Child Welfare Centres at Bedford College, Regents Park, on March 26th, 1920. *Lancet*, April 24th, 1920, page 901.

Arthur F. Hurst, M.A., M.D., F.R.C.P., New Views on the Pathology, Diagnosis, and Treatment of Gastric Duodenal Ulcer. *B.M.J.*, April 24th, 1920. page 559.

Edmund I. Spriggs, M.D., F.R.C.P., An Address on Surprises in Diagnosis. *B.M.J.*, April 24th, 1920, page 563.

Nathan Mutch, M.A., M.D., M.R.C.P., in collaboration with Jane Mutch, B.A., The Isolation of the Single Bacterial Cell. *Jour. Royal Microscopical Society*, 1919, page 221.

Pass List.

Conjoint Board.

First Examination.—Chemistry, Physics and Biology. March, 1920.

* J. H. Broadhead.	**F. Widlake.
† C. H. C. White.	† G. B. Longhurst.
† H. E. Filmer.	‡ S. R. G. Pimm.
‡ H. B. Davies.	‡ A. Broido.
* M. H. Jacobs.	† F. J. Levy.
† A. H. Lipschitz.	† F. N. Newell-Roberts.
††H. E. Lewis.	* S. F. Durrans.
* A. C. Taylor.	* E. H. Edney.
††F. Martin.	* B. M. Francis.
††P. S. Court.	* C. G. Morgan.
††L. W. Houghton.	* S. C. Olver.
**J. J. Laws.	* H. P. Yew.
**D. H. Couch.	* P. Schofield.
**L. F. Davies.	* E. G. Smallbone.
**D. F. Johnstone.	* P. G. Trafford.
**T. J. Williams.	* T. G. Tressider.
	* H. C. Warner.

*Biology only. †Physics only. ‡Chemistry only. **Chemistry and Physics. ††Chemistry, Physics and Biology.

Practical Pharmacy.

J. J. Laws.	C. T. Pomeroy.
F. N. Newell-Roberts.	E. Hardy.
S. C. Olver.	W. F. Payne.
T. G. W. Parry.	K. O. Parsons.
W. H. Bradfield.	G. C. Hughes.
D. Maximos.	E. F. Wilson.
R. G. Tame.	L. B. Helder.
A. B. Davies.	I. E. Harries.
F. J. Biddle.	H. Slater.
B. Rubenstein.	C. M. Short.
H. C. Warner.	F. W. Widgery.
M. E. P. Killard Leavey.	I. J. Bechal.
M. Hawke.	J. L. Faull.
H. W. Harvey.	G. W. V. Parry.
H. Levit.	D. S. Todd White.
S. T. Hine.	N. L. Eckhoff.
J. U. Human.	O. F. A. Krause.
T. Wooldridge.	W. A. Caldwell.
F. Woodford.	H. Evans.
I. Rosenberg.	R. R. Macintosh.
D. B. Hitchings.	J. Dywien.
	S. A. Leader.

Second Examination.—Anatomy & Physiology.

D. A. Windermere.	C. L. Kark.
* J. T. Linklater.	* E. E. Neser.
* D. S. Hammond Williams.	A. Robertson.
* G. E. Fisher.	A. F. Percy.
* R. M. L. Still.	H. C. Meathrel.
M. E. P. Killard Leavey.	N. Markiles.
E. C. Foraker.	J. S. Hudson.
P. G. Sedgwick.	W. G. R. Hore.
* M. Jackson.	* P. Hack.
*J. A. F. Denyssen.	* D. B. Whitlock.
† H. J. F. Wood.	H. P. Baylis.

*Anatomy only. †Physiology only.

Preliminary Science, L.D.S.

W. F. Hurdle.	G. Zondagh.
T. S. L. Barritt.	G. L. Shearer.
V. R. Estmont.	C. B. Wilson.
F. J. Fourie.	* C. H. A. Fido.
E. V. Hayes.	* C. C. Brattle.
L. Nurick.	* V. L. Sunderland.
W. Orsmond.	† I. M. Zondagh.
E. C. Packham.	H. D. Hall.
* P. Picnaar.	W. L. Boness.
J. F. Pilbeam.	† F. G. Davies.
† E. M. Power.	A. S. V. Daniels.
C. P. Urbain.	† V. R. Roberts.
J. E. Lloyd.	J. V. Bingay.
E. A. Lloyd.	E. H. Marshall.
L. G. Hemmings.	* S. Edinow.
F. Crone.	† G. J. Van Schalkwijk.
L. F. Handford.	† H. J. Luck.
T. L. I. Urquhart.	† M. Lewis.
O. H. M. Woodbridge.	A. Tuback.
† S. G. French.	L. N. Thorow.
J. S. Smith.	W. V. A. Hodges.
T. G. Lloyd.	* R. V. Goodson.
* A. W. Greenwood.	† S. D. Neal.
† A. P. Tupling.	* C. D. Ferris.
* R. C. Ballard.	* F. G. Hutchinson.
F. W. Watt.	* F. H. Hayns.
J. B. Hine.	† S. Borson.

*Chemistry only. †Physics only.

Marriage.

MATTOCK-COLSTON.—On the 21st April, at Great Kimble, Bucks, by the Rev. E. Foord-Kelsey, Lieut.-Colonel Norman H. Mattock (late Northamptonshire Regt.), younger son of the late Stephen W. Mattock, of Alderman's Drive, Peterborough, to Mary Emily Alfreda, youngest daughter of Edward F. Colston, The Bungalow, Hornsey Lane, Highgate.

Ed.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

ACCORDING to precedent, this issue of the GAZETTE constitutes the so-called Publishers' Number. Its object is to bring befor the reader, who wishes to keep his medical library up to date, notices of the latest scientific and medical publications.

Books always provide food for thought; they are essentially the expression of their authors' egoism and individuality, and of his desire to set down in concrete form his ideas and opinions on divers subjects Taking this into consideration, then, it is not surprising that so many bad and nondescript volumes have been penned since earliest times. It is the publisher, with one eye on the public wants and the other on his profits, who acts as a kind of censor, accepting those books which are good and usually rejecting those which are worthless.

The text-books which one usually comes across may be divided into three classes: firstly, learned books, which include such classics as Osler's Medicine, Laennec's Phthisis, and Starling's Physiology; secondly, there is the ordinary text-book, which expresses essentially current ideas and procedures, serves a useful and instructive purpose for a year or two and is presently consigned to limbo. Lastly, there is the "cram book," written with the express intention of helping the mentally lame over academic stiles.

Examples of all these types of books will be found in our advertisement columns; we commend them to our readers' notice.

IT was with great pleasure that we heard of the appointment of Dr. John Fawcett to the Council of the Royal College of Physicians and to the Senate of the University of London as Representative of the College of Physicians.

It is with the greatest satisfaction, too, that we are able to make the following announcements:—

Dr. N. Mutch, to be Fellow of the Royal College of Physicians; Dr. Ryle, to be Warden of the College, Guy's Hospital; Dr. Marshall, to be Sub-Dean of the Medical School; Prof. T. B. Johnson, to be Dean of the Medical School; and Mr. F. Bocquet Bull, to be Sub-Dean of the Dental School.

WE regret to announce the death from pneumonia of Mr. George Felce, on April 28, 1920. It was our privilege to have known him during the years that he spent at Guy's. He earned the affection of all who came in contact with him, both outside the Hospital and in connection with his work at Hospital. It was his whimsical humour, loyalty to friends, and

sportsmanlike qualities that especially endeared him to those who knew him well. All we can do is to grieve for a lost comrade and to offer to his parents our deepest sympathy in their loss.

Two more pre-war institutions have been revived, and the announcement of them in our sports columns call for emphasis. Firstly, the Athletic Sports are to be held this year at Honor Oak Park on May 29th. In addition, the Guy's Team is going to compete for the "Rosebery" Cup on the 26th instant, and for the Inter-Hospital Athletic Shield at some future date.

The great stimulus that the support of friends affords to a team is (as we have often remarked before) self-evident. It is impossible for the normal individual not to enjoy the spectacle of athletic competition, even if he is unable to take part in the events himself. This being so, we hope to see a record turn-out of Guy's men and their friends down at Honor Oak Park a fortnight hence.

Secondly, there is the Rifle Association, which at the present time boasts about thirty members. Now, it is impossible for such a Rifle Club to raise a first-class team unless it has the appropriate talent of the Hospital behind it. Everyone wishes to see the Association restored to its pre-war standard at least, and we appeal to everyone who is interested in shooting to give the Rifle Association his enthusiastic support.

In these days, when the rise of Labour is seen on all sides, when wealth is concentrated more than ever in the hands of the ignorant, and coal advances fourteen shillings on the ton, the problem of the New Poor becomes more insistent and difficult to solve.

It is not with housing and education that we are concerned here, but with the problem of the medical and hospital treatment of the underpaid professional classes.

The working man, when he is ill, has all the benefits that a modern hospital and expert advice can afford. The rich man can have these same benefits by paying for them at some private institution. But, as Bernard Shaw, points out, the nursing home is the most expensive kind of hotel in existence. To the middle-class man of small means, then, there is no middle course. If he feels seriously ill, he must either sacrifice half a year's earnings in his efforts to get well, or he must come as an out-patient to one of the large general hospitals, although he realises that such institutions are primarily intended only for the poor.

It is surely time that some provision were made for the individual in such a difficult position; it is time, in fact, that hospitals or wards were built where, for two or three pounds a week, the poor professional man might obtain board, lodging, and treatment as well.

The Mayo Clinic in America of course, caters for all classes: the very wealthy, the middle-class man, and for the poor. We do not think that such an experiment has been carried out in this country, but it is certainly worthy of a trial.

The Medical and Nursing Professions have lost a generous friend and an indefatigable worker in the death of Sir Henry Burdett, which occurred on April 29th. There can be few alive now who remember him as a fellow student at Guy's in the early seventies. But those who have come after him will readily admit that, although Sir Henry never qualified, he devoted his great talents to the cause of the sick with a zeal that has rarely been equalled even in the ranks of our profession. His death is a great loss to the nation, and we are proud, as we believe he was also, that we can call him a "Guy's man."

Acute Gonorrhœa.

CLINICAL LECTURE BY A. R. THOMPSON, Ch.M., F.R.C.S.

Gentlemen,—I will begin my lecture to-day on Acute Gonorrhœa by quoting to you what Professor J. George Adami says in his "Principles of Pathology," published in 1899, pp. 392—3, with slight modification: "The essential feature of suppuration is the profound attraction of leucocytes to the area of injury, followed by the death of a large proportion of the same, and this unaccompanied by the rapid disintegration and dissolution of the dead cells which characterised preceding grades of inflammation. There is thus found a thick, more or less creamy and opaque fluid at the site of inflammation, and on microscopical examination there is found to be a suspension of leucocytes, especially polymorphonuclear. Some of these exhibit well-staining nuclei, some have intracellular foreign matter, bacteria in various stages of degeneration, fatty and other matters, the result of phagocytic activity. These are cells presumably still active at the time of the removal of the pus. Others, again, show badly-staining, broken up nuclei: these are clearly degenerated and dead cells. The fluid from the pus contains much protein, the results of tissue destruction and leucocytic disintegration."

Now there are differences to be found in the so-called pus of gonorrhœa, as contrasted with pus as described by Professor Adami. A very superficial acquaintance, through the high power of the microscope, with the appearance of the pus from an urethral discharge will convince you, I think, that, apparently, none of the leucocytes appear to be degenerated. First, we have the polymorphonuclear cell, which is extremely common. It has, as its name indicates, a nucleus which is variously formed. Those are the most common cells which you find in gonorrhœal pus. You will also find large epithelial cells, which may be either quadrangular, with a small oval nucleus, or it may be hexagonal. You may, likewise, find small epithelial cells also with a small oval nucleus. Those two kinds of epithelial cell indicate that there are two different types of epithelium in the urethra: there is the transitional epithelium of the urethra, near the meatus. Further back there is stratified epithelium, and it may be that the small epithelial cells come from the transitional epithelium near the meatus, and that the larger epithelial cells come from the urethra further down.

That at once brings us to a consideration of the importance of a microscopical examination, because if what I say holds true, namely, that the small cell comes from near the meatus, and the large cell comes from further back, clearly if, in previous examinations, you have seen no large epithelial cells, yet as the disease goes on, you one day see large epithelial cells, the disease must now have spread further back, and in that event the prognosis is a little worse than it has been hitherto.

In addition to those cells, a few mononuclear leucocytes, which are about the same size as the polymorphonuclear, and contain a nucleus which almost fills the whole cell, may be seen.

The living character of the cells is a very marked feature in connection with the examination of pus from a case of gonorrhœa. You may study field after field under the microscope without finding a degenerated cell. If a film is prepared from the pus of an acute case it differs considerably from a film prepared from a swab passed down the urethra. In the latter you will find a fair number of polymorphonuclear leucocytes, you will also find epithelial cells which the wool of the swab has succeeded in dragging off from the underlying tissue, and you will find epithelial cells stuck together as if a largish mass had been taken off. Lying upon those epithelial cells you may find groups of gonococci. These are an aggregation of what I call the units of the gonococci. A unit of the gonococcus is a diplococcus. It is found to be somewhat bean shaped, or kidney shaped, the Americans describe it as "biscuit shaped," which is not so descriptive, and there is an interval between the elements of the unit of about the breadth of a unit, or rather less. Now, such a group of units you find upon the epithelial cells. And you will find isolated units scattered about the microscopic field.

In the examination of the film which has been prepared directly from the pus you will find quite a different picture, and before deciding, by the microscope, as to the stage of the disease, you will be careful to form your estimate upon an examination of both films. In the pus, you find the polymorphonuclear leucocytes in some places crowded with intracellular groups of gonococci, and it is an interesting

point in cellular pathology that occasionally you may find an isolated lobe of the nucleus surrounded by intracellular groups of gonococci. I cannot say, at present, whether that is of any practical significance.

That is practically all that the books say about gonococci, that you have isolated units, and that you have intracellular groups. Some of the more advanced French books go on to describe gonococci being found, in the first stage, on the epithelial cells, as I have indicated already to you. Some of them say that the groups eventually become isolated units, as in the passing away of the disease. But I do not think that goes far enough. I believe there is a definite relation between these isolated units and the formation of groups. I have got slides at home, and I am willing to let any of you who like to see them, and would welcome an examination of them.

Occasionally, in a polymorphonuclear leucocyte you find a group whose units are dispersing and quite widely separated from each other.

You may find another polymorphonuclear leucocyte with a group with the units aggregated quite closely together.

I call that an aggregated, or a closely-set, group. What is the difference? The first, I think, is a dispersing group, one which is leaving the cell. The other is a queue, or group of cocci, waiting for admission into the cell, or to be taken up by it. I think you can see a distinct difference between the dispersing group and the group which is becoming collected together in order to be taken into the cell.

If you examine other smears—and, of course, all these changes cannot be seen in one day, or even in one week—you will find what I call a "mother group"; that is to say, under the microscope you will find, in one field, isolated units scattered about, and in the centre of that area which is surrounded by isolated units you will find a polymorphonuclear cell with a dispersing group of gonococci passing in all directions to form these isolated units.

In addition, we may also find in smears, the next day or in a day or two, in that mother group system, that there are no isolated units at all, but there are intracellular groups of gonococci. And I suggest that those isolated units, which have been dispersed from one cell, or have themselves dispersed from one cell, have become other extracellular groups which will enter or be taken into polymorphonuclear cells. I think during the past year I have made that out sufficiently to be quite certain that that is the process which is going on as regards gonococci in a case of acute gonorrhœa. We have ,in other words, gonococci on the epithelium, in the early stages, passing to, or being taken up by polymorphonuclear leucocytes; we have them dispersing from those polymorphonuclear leucocytes as isolated units. Those isolated units are capable of forming extracellular groups, and those extracellular groups are capable of being taken into, or entering as such into the polymorphonuclear leucyte.

I venture to think that is a very important point in connection with the treatment. I think that if there are groups of gonococci inside the leucocytes, and if there is no sign of dispersion of those groups from the leucocytes, local treatment may not be as valuable as when the groups are dispersing, except in so far as it gets rid of leucocytes. That is the time for treatment. If you can be sure local treatment is going to be efficient, you may irrigate the urethra in that stage. If, however, you are going to be careless, neglectful, or perhaps too tired to do anything in the nature of an efficient wash-out, or if your fluid or apparatus are not the best which can be obtained, you had better not attempt such treatment locally. I believe that at that time, and under these disadvantageous circumstances, where you have dispersing groups with extracellular gonococcal units, you had better administer sandal wood oil. I think the sandal wood oil of Dr. de Savaresse is the best; it is in capsules. I had a patient the other day I gave sandal wood oil to, and he told me that if he took it over night, he still had the taste of it in his mouth in the morning. He was an intelligent patient, and I can imagine it would be a drawback to the treatment, because its taste and small are offensive.

I now wish to go on to another new point in connection with the treatment of acute cases of gonorrhœa. Colloidal silver has been extensively used in the treatment of gonorrhœa. But I felt that, in addition to the antiseptic treatment, there should be something capable of destroying the leucocytes in order to get at the gonococci. If the gonococci are surrounded by leucocytic material it must be very difficult

for any antiseptic to get at them, and my view was that the leucocytes should be killed, if possible, and I came to the conclusion that a digestive agent might be useful. There are certain disadvantages about the animal digestive substances. Pepsin, I take it, must have acid with it, and the acid might be harmful to the urethra. Trypsin, I am told, is dirty bacterial stuff, and I felt I could not be sure it was clean when I put it in. It occurred to me that papain, which is the digestive ferment extracted from the papaw tree, might be extremely useful. I have used it for a long time in connection with the better digestion of boric acid in the treatment of septic conditions of the urinary tract, and I think the patient can take a bigger dose of boric acid when an equal quantity of papain is given. I looked up the question in Sir William Hale White's book on Pharmacology, and I found a small paragraph on papain by Dr. Sydney Martin, of University College Hospital. I found that papain had been used in diphtheria, but was only historically interesting. That did not worry me, because unless you can keep a digestive ferment up against the material you wish to digest, it is of no use having it. I thought that whilst it might be difficult for a patient with diphtheria to keep a bolus of papain in the upper part of the larynx and so in contact with the membrane, it would be easy enough to keep papain in contact with the disease in the urethra of an individual.

The next thing was to find out whether papain was affected by the use of strongish antiseptics, and I found that digestion took place with papain and argein pretty comfortably, that papain with even such a strong antiseptic as oxi-cyanide of mercury (1 in 1,000) was not destroyed. Therefore, I thought papain could be used in connection with some antiseptic which should kill the leucocytes and kill the gonococci.

Last Wednesday, 28th April, a man turned up with acute gonorrhœa. I have notes of his case, and I am, to a certain extent, confirmed by Dr. Laidlaw, whom I asked to see the slides. I can supply the detailed history, but I may say he had an acute attack of gonorrhœa. He has a small meatus, and that was a great disadvantage to me. I think, on examination of the pus, Mr. Biddle will agree with me that the first specimen of pus shows some intracellular groups, some dispersing and some isolated units. Swab No. 2 showed a great number of isolated units, and some dispersing groups, and there were two groups in the epithelial cells. He was admitted to Cornelius that afternoon, at 3 o'clock, and I gave him $\frac{1}{4}$ gr. of morphia. We then inserted some bougies, made up of collargol iii gr., papain vi gr., paraffin q.s., in Guy's Dispensary, and Mr. Lansdowne very kindly assisted me. After the patient micturated, a fresh bougie was inserted, and in that way continuous bougie treatment was kept up for twenty-four hours. On the day following, Mr. Laidlaw confirming, there were very few intracellular groups; we both had to look very carefully before we could find any groups. There is one small group at the periphery of a lymphocyte. On the 30th, *i.e.*, the following day, the bougie treatment continuing, the film which I got was not a good one, but I did not see any gonococci at all. He went out, and said he was coming up on Saturday morning, but he did not.

Fortunately—for us—a patient, a lad of 19, who had contracted gonorrhœa about eight months ago, presented himself for treatment. He said there were frequent exacerbations of the disease, and eventually he came to see me, and said he would undergo anything which I thought proper if only he could get rid of his disease. He was admitted to Cornelius on the 30th April. Bougies were inserted at 4.30 in the afternoon. There was a long, loose foreskin, much pus, and a great deal of balanoprostitis. Gonococci were found as follows: There were a great number of intracellular groups, comparatively few isolated units. In the swab there were some intracellular groups which were dispersing, and there were a great number of isolated units. The bougies were retained—save for the micturition intervals—for nearly twenty-four hours. When the patient came to see me at my home, I took a swab and made a film, and I could not see any gonococci in it. The picture was entirely different from what I had expected.

From these two cases (and another one I saw after this lecture was delivered) I am encouraged to carry out treatment along these lines.

In conclusion, I would say that I am much impressed with the idea that in early cases of acute gonorrhœa, *continuous* local treatment is very necessary and patients should be prepared to go to bed for two days and be put on light diet.

Cerebral Tumours and the Indications for their Surgical Treatment.

BY C. P. SYMONDS, M.D., M.R.C.P.

"The desiderata in the treatment of brain tumours are to save life, to prolong it, and by no means least in importance to ensure that the gain in years may be worth having"; a truism perhaps, but the fittest introduction to the present paper.

The classical symptoms of cerebral tumour given in text-books of medicine and surgery are headache, vomiting, optic neuritis, and fits, and it is of the highest importance to realise that of these the first three are, as a rule, *late* symptoms. They may be, as far as our present methods of investigation can discover, the only symptoms, but they indicate a considerable increase in intra-cranial pressure, which means the existence within the cranial cavity of an extraneous mass either (1) of considerable size, or (2) in such a position as mechanically to obstruct the outflow of the cerebro-spinal fluid. It is tumours of this latter class, compressing the Sylvian aqueduct or fourth ventricle, which give rise to internal hydrocephalus in their early stages and thus form an exception to the general rule which I have stated above, that the symptoms of raised intra-cranial tension are later symptoms of cerebral tumour.

Now a consideration of the statistics showing the results of operative treatment of brain tumours leads at once to the conclusion that when a tumour has been successfully localised the earlier the operation is performed the lower is the operative mortality, and the higher the number of complete cures. It therefore follows that it is the business of the physician to localise the tumour *before* the classical signs of increased intra-cranial pressure are in evidence. How far this may be accomplished in the light of our present knowledge of cerebral function, and by what methods, I propose to show briefly in a succeeding paragraph.

The indications for operative interference and the method of choice depend also upon the actual site of the tumour when localised. Thus, whereas it would be justifiable to perform an exploratory operation in the case of a tumour of doubtful nature in the region of the right pre-central or angular gyrus, this would be bad practice on the left side on account of the almost inevitable disturbance in the spheres of speech and intellect which would follow.

The other most striking fact which emerges from the statistics is the dependence of successful treatment upon the *nature* of the tumour. The two commonest types of neoplasm are the glioma, a growth beginning in the cerebral substance, of variable rate of increase but essentially malignant in type and liable to recur after operation, and the so-called endothelioma arising from the meninges, of slow growth, benign type, and capable of complete removal without liability to recurrence. It would be of great importance, therefore, to be able to gauge accurately the nature of the tumour before or at operation. For instance, in the hypothetical case of a tumour encroaching upon the speech centre if we knew this to be an endothelioma we should be justified in urging operation with the prospect of complete cure of the symptoms due to the tumour as an asset against the possibility of some degree of post-operative aphasia; if we knew it to be a glioma it were better left alone. For it appears not only that gliomata are irremovable, but that the disturbance at operation of the natural tissue barriers around it may result in an increased rate of growth.

It is possible in some degree to diagnose the nature as well as the site of an endothelioma before operation, bearing in mind that these tumours are always in the first instance superficial, and of slow growth. Being superficial they give rise early to phenomena of cortical irritation, e.g., in the pre-central area to motor fits, in the post-central area to subjective sensory phenomena—as will be described below. Moreover, they, in common with other superficial tumours, often produce a sign of great importance, namely localised headache, and localised tenderness on pressure over the site of the tumour. In virtue of their slow growth they give a history often extending over years and of gradual development.

At operation the bone overlying the tumour is often found to be much thickened and abnormally vascular, and it may be possible after opening the skull to observe at once that the mass is growing from the dura—the superficial surface of which at the point of attachment is thickened and opaque—and has excavated for itself a hollow in the surface of the brain. Not infrequently, however, the tumour may grow from the falx cerebri by a comparatively narrow stalk, and burying itself in the mesial aspect of the brain may thus seem to be of deep origin. It is therefore necessary in suspected cases of this type to explore along the falx for the point of initial growth.

These tumours are as a rule nodular encapsuled masses from the size of a walnut up to that of a hen's egg, and are enucleated with comparative ease, yet the operative mortality from hæmorrhage and shock is disappointing. Some surgeons prefer to perform the operation in two stages, (1) craniotomy and decompression (2) seven to ten days later-removal; but the operative mortality does not ap-

pear to be materially reduced by this procedure, and the balance of opinion on the whole favours complete removal at a single operation.

The gliomata arise in the substance of the brain Their rate of growth is uncertain and variable, but on the average they give rise to a history of shorter duration than the endotheliomata. If in the neighbourhood of the Rolandic fissures they are likely to produce weakness and loss of sensation in the corresponding limbs *before* giving rise to Jacksonian attacks, motor or sensory. The occurrence of Jacksonian attacks means that they are involving the cortex.

For the reason given above it is doubtful whether it is ever justifiable to perform more than a decompression operation for a glioma. The best case for an attempt at removal would be in one of the so-called "silent" areas of the brain, but, as the term implies, it is in just these situations that it is impossible to make an accurate localisation. It must, however, be borne in mind that when a tumour has been localised, an operation of an exploratory nature, with removal of a small piece of the growth for microscopical section, may be necessary to determine its nature and so decide the ultimate possibility of removal.

When, therefore, the diagnosis of cerebral tumour has been made and a localisation arrived at, early operation is indicated. The dangers peculiar to an exploratory craniotomy must here be considered. In the hands of a surgeon experienced in this kind of work, and provided that there is no gross increase of intra-cranial tension, the risks are not great, but the operation cannot be regarded so lightly, for instance, as an exploratory laparotomy. In the first place there results a gap in the skull, which—as war wounds have shown—may cause the patient serious inconvenience, apart from deeper trouble. This difficulty may be met in the case of successful removal of an endothelioma, or a negative exploration, either by fashioning an osteoplastic flap at operation, or by performing a second operation for closure of the opening either with a bone graft (preferred by Trotter) or by means of the "celluloid sandwich" successfully employed by Sargent. In the second place there is always the risk even after a simple decompression of death from internal hæmorrhage. The sudden release of external pressure appears to result in rupture of vessels, often into the lateral ventricle, a disaster which one cannot tell how to foresee or prevent. In the case, then, of a doubtful diagnosis these risks must be weighed, and it may prove wise to await more definite signs to turn the scale in favour of operation.

Before proceeding to a discussion of special points arising in connection with different areas of the brain, I should like to emphasise two more general considerations of great importance:—

1. A routine examination of every suspected case of cerebral tumour should be made to exclude other possibilities. If there is any evidence of otitis media past or present, the possibility of abscess must be considered, and the opinion of an otologist obtained. A Wassermann should always be performed with blood and cerebro-spinal fluid (a few c.c. only of the latter being required). X-ray plates may reveal calcareous masses of tuberculous origin.

2. In assaying the value of certain localising signs in the presence of increased intra-cranial pressure, it must be remembered that this alone may be responsible for isolated cranial nerve palsies —especially of the sixth and seventh, an extensor plantar response, aphasia, or mental defect. In other words, early localising signs are of much greater value in determining the site of a tumour than those which occur later, together with signs of grossly increased tension.

Tumours in Special Areas of the Brain.

A. *Pituitary Tumours.* These are so completely dealt with in Cushing's monograph and their localisation is so easy that little need be said about them in this paper. The results of operative treatment, however, even in the hands of the most expert surgeons are disappointing, the most successful results being obtained in the case of the rare cyst, whose contents are easily evacuated. The best method of approach in the hands of English surgeons is that obtained by a lateral craniotomy as far forward as possible; the frontal lobe being then lifted up a fair view of the optic chiasma is obtained. These patients are often comparatively free from suffering, and the indications for operation vary in individual cases, the best that can be hoped for being relief of headache, and some degree of recovery of vision.

B. *Tumours in the Cerebrum proper,* i.e., in the anterior and middle fossæ.

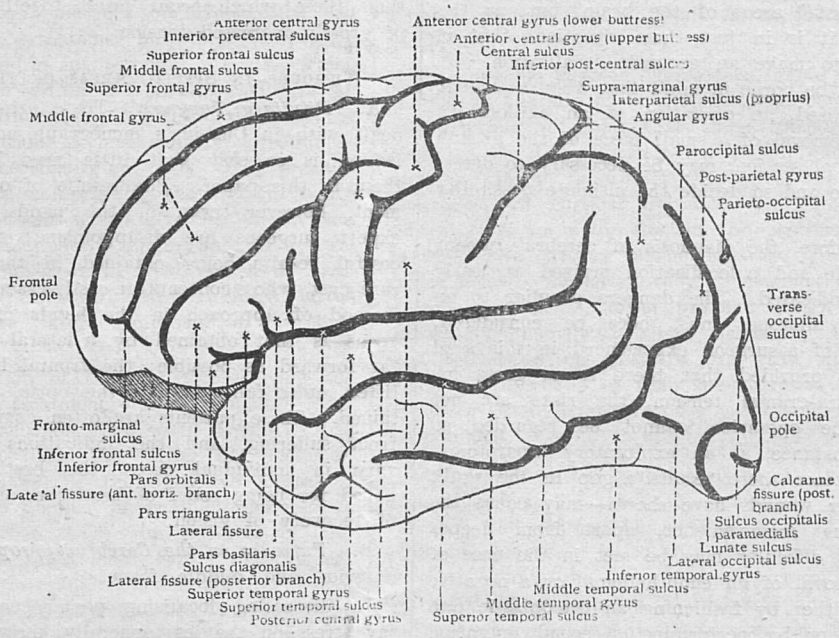
In discussing localising phenomena, I intend to lay stress on the less generally known points. The distribution of function is most fully differentiated in the cortex; the more superficial the lesion, therefore, the more localised will be the disturbance of function. The arrangement of the motor centres in the pre-central gyrus is sufficiently well known and the significance of Jacksonian motor attacks in connection with cerebral tumours widely realised. Paresis due to an incipient lesion in this region is not always at first easy of recognition, and it is to be borne in mind that it is movements not muscles that are represented in these motor centres, and that the movements for the hand thus laid down are much more numerous and more delicate than those of the trunk and lower limb, so that paresis of the arm and hand is more likely to be detected with precision at an earlier stage.

Far less frequently recognised are the sensory Jacksonian attacks, and cortical sensory loss due to lesions in the post-central gyrus. The sensory attack consists as a rule of a vague "funny feeling" commencing in hand or foot with a tendency to spread similar to that of the motor seizure. The irritation may spread from sensory to motor cortex, and the initial sensory area is thus easily missed. The sensory loss is of a peculiar type. There is little or no defect in the appreciation of crude touch, pin-prick, heat or cold, but there is loss in varying degree of one or more of the three following elements of sensation described and localised by Henry Head as follows:—

1. Spatial recognition, i.e., sense of position, power to discriminate compass points and to indicate a spot touched; localised in the Rolandic fissure.

For instance, in a patient with suspected cerebral abscess the localisation depended entirely on inability, with her eyes shut, to name or describe cotton wool or a key when placed in her left hand, although she had no difficulty in doing so when they were in her right. There was in this case no loss of superficial sensibility and very little of sense of position, but there could be no doubt whatever as to the site of the lesion, which was proved at operation.

Passing now to the occipital lobe it seems necessary to emphasise the fact that the visual fields should be at least roughly examined in every case of cerebral tumour. Recent researches indicate that the macula on each side is unilaterally represented in the posterior tip of the occipital lobe and that the remainder of the field of vision is served by



2. Ability to recognise difference and similarity of objects in respect of size, shape and texture; this is localised in the post-central gyrus.

3. Appreciation of differences in intensity of touch, pin-prick and temperature; localised somewhat widely in the cortex, backwards from the post-post-central fissure towards the occipital lobe.

The signs of a lesion in this area then may be obscure, and only recognisable by means of fine investigation.

Here again it is important to realise that the hand being far more highly trained in exploration of the environment than the lower limb or trunk, has its sensory functions represented over a correspondingly wider field of the cerebral cortex.

the occipital cortex in concentric circles, advancing forward from this point, from centre to periphery. In front of this are the higher visual centres, localised lesions of which have been shown to be capable of producing the most bizarre symptoms, such as loss of appreciation of depth, etc.

The subject of aphasia is too big to be dealt with here. It is sufficient to point out that in right handed persons a lesion anywhere near Broca's area is liable to produce motor aphasia, i.e., a condition in which the patient knows what he wants to say but cannot say it. The deeper the lesion the more likely it is to produce a complete aphasia, since the fibres from higher centres to the speech musculature converge on their downward path and are thus more liable to be damaged *en masse*.

The speech centre proper is localised in and around the angular gyrus, extending backwards towards the occipital lobe and downwards to include the posterior ends of the first and second temporal convolutions. Any lesion in this area leads inevitably to more or less mental impairment.

Patients with tumours encroaching upon the uncinate gyrus, at the anterior extremity of the temporal lobe, are subject to very characteristic seizures which are often unnoticed unless specially enquired for. The attack consists of a quite transitory dreamy state, lasting for a few seconds. The patient commonly fancies that he can see someone whom he ought to know but cannot recognise. This is followed by an unpleasant taste or smell, which is so real to the sufferer that he will often spit in order to get rid of it. These attacks may recur at frequent intervals without any loss of consciousness and the patients as a rule make little of them. But they are of the greatest localising value.

We have now to consider the two large "silent areas" of the brain, the frontal and the temporal lobes. It is a well-known and unfortunate fact that tumours in either site may grow to a size large enough to cause death from intra-cranial tension, without giving rise to any localising signs which we can recognise with our present methods. Frontal tumours are thought to be especially associated with disturbances of temperament. The first symptom, for instance, of one patient with a glioma of the left frontal lobe was a rapidly increasing irritability in his relations to his family. He could not tolerate the noise of his children's playing, and having before been of a patient and affectionate disposition would now throw crockery at his wife on the slightest provocation. It must also be remembered that motor Jacksonian attacks may be due to spread of cortical irritation from a frontal tumour. In this case the fit will not be associated with a true paresis, but is followed by a temporary exhaustion weakness.

Patients with tumours of the temporal lobe are more likely to show defects in this sphere of intellect, and on the left side in right-handed persons the speech centre may be affected, if the lesion be far back.

It is in connection with these tumours, and those situated deeply within the cerebral substance, that there arises the question of operation for simple decompression. In the absence of localising signs this should be done for insufferable headache, or at the first sign of seriously diminished visual acuity, but in the absence of these two indications operation should be postponed in the hope that a localisation may become possible. In the performance of such a decompression the best site is in the sub-temporal region, and it is important to make a large enough opening in the skull, for in these cases the intra-cranial tension is so high that when the dura is opened the cerebral substance is apt at once to bulge and a hernia to develop unless there is wide room for expansion.

C. *Sub-tentorial tumours.* These may again be divided into those arising within the cerebellum and pons and those growing from without. The pontine growths may be disregarded from the point of view of this paper, being unamenable to surgical treatment. Into the symptomatology of intra-cerebellar tumours I do not propose to enter here. The account given by Gordon Holmes of the results of gunshot wounds of the cerebellum (Brain, 1917) is a lucid and complete exposition, which applies equally to destruction of the cerebellum by tumour invasion. It may be remarked, however, that intra-cerebellar tumours give rise to papillœdema and other signs of increased tension as a rule early in their symptomatology, that the cerebellar signs may need careful elicitation even in cases of wide destruction, and that they may vary a good deal from day to day, being most apparent when the patient is tired.

Unfortunately the great majority are gliomata, for which nothing can be done, but the occurrence of an occasional cyst or innocent tumour makes exploratory operation justifiable. If, however, no *removable growth is revealed after the dura has* been opened further exploration is absolutely contra-indicated, being nearly always followed by death, and even the simple decompression often results in necrosis and sloughing away of most of the cerebellum—the result of œdema due to the release of pressure.

Of the extra cerebellar tumours those which have attracted most attention are those described by Cushing as tumours of the acustic nerve. These are neuro-fibromata arising from the sheath of the eighth nerve often bilateral and sometimes associated with multiple neuro-fibromata elsewhere. They are benign tumours of slow growth and give rise to a somewhat characteristic progress of symptoms, of which the essential feature is nerve deafness, often preceded by subjective symptoms such as whistling noises in the affected ear. The fifth nerve is next usually affected, of which the first sign is loss of the corneal reflex. Later all the nerves in the cerebello-pontine angle are affected, and the tumour encroaches upon the cerebellum, giving rise at this stage to papillœdema, headache and vomiting, as well as the signs of cerebellar involvement.

These growths have to be differentiated from others occurring in the same situation, most frequently sarcomata arising from the base of the skull, the most important diagnostic points in favour of acustic tumour being

1. The early involvement of the eighth nerve as determined by otological examination, and

2. The length of the history.

Operative treatment, even in the hands of Cushing, who has had great experience, is so far rather unsatisfactory on account of the inaccessibility of these growths. Attempts at complete removal are attended with a post-operative mortality so high as to render them unjustifiable, but Cushing has obtained encouraging results by his method of decompression with partial removal, repeated if necessary when symptoms recur.

This paper does not intend in any sense to be a complete account of the subject, but is offered as a rough sketch of the commoner problems met with by physician and surgeon in the differential diagnosis and treatment of intra-cranial neoplasms.

The Treatment of Peritonitis by Peritoneal Lavage.

In connection with a recent article in the *British Medical Journal* of April 17th on the treatment of septic peritonitis by Mr. F. J. Steward, the following notes may be of interest.

K.S., a girl aged 13 years, was admitted into Lydia on the 24th of April last with a diagnosis of appendicitis. She was operated on at once, and a gangrenous appendix was removed. There was a diffuse septic peritonitis with feeble adhesions more or less limiting it to a wide area. The fluid was removed as far as possible, and four Carrel tubes inserted, two in an upward direction and two downwards towards the pelvis. A large drainage tube with multiple holes was placed as far down as possible into the pelvis.

The patient was placed in the Fowler position as soon as she became conscious, and irrigation started. Two ounces of normal saline were run in every half hour, this ensured that all the four Carrel tubes were supplied with saline. A medium-sized drainage tube with a serrated extremity and two terminal holes was placed inside the large drainage tube and connected with a water suction pump with a bottle to trap the fluid.

The suction was commenced immediately after the saline, and at once commenced to remove purulent fluid. The following shows the amounts run in and removed:—

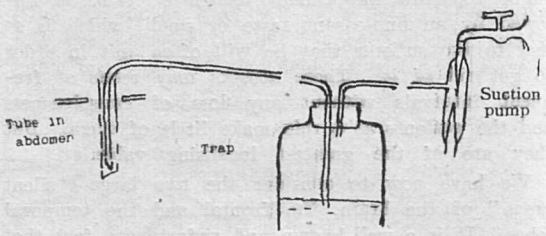
	Saline Entered.	Fluid Removed.
	ozs.	ozs.
Day 1	22	10
,, 2	96	43
,, 3	52	35
Total	170	Total 88

This shows that 51·7 per cent. of the fluid run in was removed by suction. The drained-off fluid was blood-stained and purulent for the first few hours, but rapidly became clear.

The dressings remained perfectly dry during this period, and even the gauze over the wound was dry when it was removed.

Despite the serrations at the end of the suction tube, this tube tended to become adherent, and had to be frequently twisted to prevent this.

The increased comfort which dry dressings gave the patient was most satisfactory.



The tubes were removed 36 hours after the operation, and one Carrel tube left in. The patient made a remarkably good recovery without interruption.

The above figures show that only about 50 per cent. of the saline was sucked off, and it must therefore be concluded that the remainder was absorbed by the peritoneum, a total of over 4 pints. This was undoubtedly of great service in improving the patient's condition.

I am indebted to Mr. F. J. Steward for permission to publish these notes.

E. BIDDLE.

Papers by Guy's Men.

H. Barber, M.D., A Case of Tuberculous Meningitis with Complete Recovery. *B.M.J.*, May, 1920, page 601.

R. O. Moon, M.D., F.R.C.P., A Lecture on Hunt Affections in Relation to the Labour Market. *B.M.J.*, May 8th, 1920, page 628.

W. Ramsden, M.A., M.D., Vitamines. *Dental Record*, May, 1920, page 281.

G. F. Still, M.D., F.R.C.P., F.I.C., and another, Orbital Hæmorrhage with Proptosis in Experimental Scurvy. *Lancet*, May 8th, 1920, page 1,008.

G. T. Wrench, M.D., B.S., Studies in Ankylostomiasis: No. IV. *Indian Journal of Medical Research*, 1919, vii., page 475.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

To the Editors,
Guy's Hospital Gazette.
Most genial Editor.

Though alas but little skilled in the subtleties of your language, I cannot be so unmindful of the kind courtesy which you have ever extended to me, as to neglect your renewed invitation to unburden my unbalanced mind in the paragraphs of your notorious publication. Few periodicals have such a wide influence in the far east as this your *Guy's Gazette*. Your illuminating insight into all matters which matter is with us a proverb. Your penetrating perspiscacity and unparalleled prescience has permanently perplexed and pleased us all. I hope shortly to send you the first edition of my book entitled "Ho Ho's Who's Who at Guy's," but for the moment I must confine myself to answering your questions about my views of your examination system at the College of Surgeons. As a Chinaman I can do no more than tell you the truth. I think your examination system is a farce. For surely your Darwin has told us that the object of competition is the elimination of the unfit, yet your examiners I am told eliminate all your men of reason. With us it is of little consequence how the examination is made because the public only pay the doctor so long as they are well, so that we have no interest in studying prolonged illnesses, besides, ever since your Wizard Chemist at Guy's discovered that intelligence is a compound of thought stuff with methylene blue, we in China have lost all respect for it. but you, who are a sagacious civilisation, grounded upon the rigid rock of scientific research and surrounded by water, have surely a place of honour for originality! How foolish then that your examiners of the College of Surgeons want students to all think alike. Where is the chance of progress? You have probably heard of Chu Chin Chow. Poor Chu Chin was a respectable medical student in Hong Kong before he came to London and went on the stage breaking his poor mother's heart. This last name Chow he has picked up with many other things in London, but with us he was just plain Chu Chin. Certainly I believe he would never have drifted to the stage had it not been for the unsympathetic attitude which the examiners at the College took towards him. Perhaps, too, his marriage with a young nurse whom he discovered at the last moment did not know how to keep the steriliser hot, helped to hurry him to misfortune. but it was certainly the behaviour of the examiners which hurt him most.

He confided in me that they took up an entirely stupid attitude towards him. One examiner said to him "Well my lad" (Chu Chin had finished his second dentition). "Well my lad, what do you know about the development of the bones of the hand?" "Why, Sir," replied young Chu Chin, "to be frank with you, I would have much preferred a question on the foot, but if, as I take it, you persist in looking at the matter from the point of view of the order primata wherein the upper extremity has, through adaptation to environemental conditions upon the lines indicated by your illustrious philosopher, Darwin, developed into the chief organ of prehension, if not of locomotion, then I must reply that my knowledge of this branch of human morphology is not specialised."

In the *viva voce* part of the examination poor Chu Chin was equally unhappy. The examiner asked what I suppose was a fair question, namely "What is the relation of the œsophagus to the pericardium at the level of the fifth dorsal intervertebral disc with the patient in the position of least resistance. that is, with the least volume and greatest space." I forget my anatomy entirely and may not have rightly visualised the question, but I suppose the answer was expected as briskly at the knee jirk which indeed Chu Chin told me he felt inclined to give the examiner. The fact is, however, that poor Chu Chin quite failed to grasp the point that speed is the essence of response. He began his reply as follows: "At an early stage in the development of the human egg and before the heterogeneity of the undifferentiated blastoscœle has given place to homogeneity, and the somatopleural mesoblastic tissue which surrounds the primitive pericardial viscous prior to the development of the obliquities of the cephalic folds, etc., etc. . . . " I am perhaps not entirely surprised that the examiner interrupted him on this occasion.

Yet in spite of these errors, if errors I may call them, I believe poor Chu Chin might have passed successfully had not misfortune overtaken him right at the end of the clinical examination. He was told to examine a case in the corner of the room, and he experienced, as he told me, some difficulty in obtaining any reasonable answers to his enquiries. On his return to the examining table he was asked for his diagnosis of the case he had seen. He described his patient as of a low developmental type with a singularly vacant and unintelligent look and alternately irritable and sullen manner. "He seems," said Chu Chin, "to be unable to concentrate his attention and rather thinks himself here as an overseer of all the others, than as a patient himself. I take him to be without doubt either dementia precox with alcohol, or parancia horrida with the spirochæte." Unfortunately the patient whom Chu Chin had tried to cross question was the presiding

examiner. I feel that in this instance Chu Chin was tactless.

Your Humble Servant,

HO. HO.

PLEURAL HERPES.

DEAR SIR,—The following case may be of interest to your readers.

C.C., male, aged 50, consulted me recently for acute pleurodynia on the left side that had come on twenty-four hours previously. There was nothing noticeable about the chest wall, the movements were free, but deep inspiration increased the pain. There was no dulness over affected part, but on auscultation there was a harsh pleuritic rub commencing below the angle of the scapula and extending round the left base to the anterior axillary line. It appeared an ordinary case of pleurisy. On the following day I was surprised to find below the nipple in the seventh intercostal space a commencing patch of herpes. There were no patches further back in the intercostal space. The herpes ran a normal course, and the pleuritic rub was well marked for three days and then disappeared. At no time was there any evidence of effusion nor did the area of the friction-sound increase. It was most marked at the lower angle of the scapula and in the posterior axillary line, and confined to the one level. There was little or no cough, and the temperature never reached 100°.

The respirations never exceeded 20. At present (three weeks after the attack) there is slight neuralgic pain about the site of the herpetic eruption, but no abnormal physical signs about the lung, deep respiration causing no pain, nor can I detect any signs of adhesions.

I think I am justified in assuming that the terminals of the seventh intercostal nerve that supply the parietal pleura were affected in the same manner, and those terminals supplying the skin below the nipple, and that there was an inflammatory roughening of the pleura.

It is noticeable that the other points of selection farther back on the course of the nerve showed no cutaneous lesion.

It is interesting to speculate whether this affection of the pleura may not be more common, but overlooked through want of auscultation. When pleurodynia is complained of, and a herpetic eruption of the skin is found, one is satisfied that the cause of the pain is obvious, and auscultation is neglected.

I might add that herpes is rife at present in this neighbourhood, and that I have met with one case of affection of the third division of the fifth causing severe ulceration of one-half of the palate, and another case where the third sacral suffered, giving cutaneous lesions on the buttock, perineum and scrotum.—I am, &c.,

G. HERBERT PENNELL.

DEAR SIR,—In his admirable letter published on May 1st, your correspondent, Dr. H. Knight-Rayson, states "that moral teaching by the Church, etc., has been a failure in preventing venereal disease is patent." I submit the attitude of the Church as regards immorality and venereal disease is unintelligible.

Daily throughout rural districts the Church knowingly legalises immorality. The marriages thus contracted are frequently most unhappy and undesirable.

This camouflaged immorality is productive of venereal disease. On the subject of divorce the Church adopts an indefensible position and advocates measures which are well known to produce further immorality.

In view of the difficulties that the Church, which still has some power, puts in our way it is very necessary, as your correspondent writes, for us, as medical practitioners, to be true to our profession and give every one a chance of avoiding disease, whether it be venereal or otherwise.—I am, yours faithfully,

MENS SANA IN CORPORE SANO.

May 7th, 1920.

SIR,—May I encroach upon your space to ventilate again a grievance which has been the constant complaint of the studious for many years past. I refer to the invariable lack of quiet in the Wills' Library.

This splendid library was donated to the Medical School as a place in which one might study the books it contains. As such it is a snare and a delusion.

There are doubtless those who can read amid a constant undercurrent of whispered (?) conversation. Personally I confess I cannot. I am content with nothing less than absolute silence, and in the Wills' Library and Gordon Museum (except when a class is being taken) absolute silence should reign. It should be an understood thing that no one should stop to pass the time of day with his friend in passing through, or carry on any conversation whatever with the man sitting next to him.

Personally I gave up attempting to work in the library long ago. I venture to make this plea on behalf of the younger men, among whom many doubtless feel as I feel, that there is no half-way course, and that unless absolute silence is maintained the large sum expended by a generous benefactor in building the library will have been absolutely wasted.

One can keep books in any old room. In this beautiful library with its large accommodation for readers let each one think of the peace of his neighbour.—I am, Sir, Yours etc.,

HOUSE OFFICER.

Guy's Hospital,
London, S.E.1.
May 10, 1920.

SIR,—I was interested in reading Mr. Blaker's charming book, "Sussex in Bygone Days," to come across the lines entitled "Sussex Farmer's Old Wife." I heard this song in Essex some thirty years ago, and it was commonly sung at the harvest suppers there. It ran

"There was an old farmer in Essex did dwell
(Bravo! Patterson, good old Patterson)
He had a bad wife, as many knew well
(Bravo! Patterson, good old Patterson)."

At the end of each verse was a chorus:

"With a folda-ar, folda-ar, folda-ar dä."

The word "bashed" was substituted for "knocked" in the line:

"She up with her pattens and *bashed* out their brains."

There was a final verse also describing the chagrin of the farmer on getting his wife back.—Yours faithfully,

A. PERCY ALLAN.

Croydon.
May 9, 1920.

DEAR SIR,—Hearing of the death in Bright Ward of Mr. Henry Milsom, late proprietor of the "Ship and Shovel," I thought that you might like a few details of his life.

Mr. Milsom has been associated with the Hospital for about half a century. It is now fifty years since he first catered for the Residents in one of the old empty medical wards, and when the College was built in Maze Pond he was asked to take charge of the catering there, but he refused owing to the pressure of other business. He was accordingly presented with a gold watch by members of the staff in appreciation of his services, and he was always proud to show it to his guests and tell them little anecdotes of what happened at Guy's forty and more years ago.

Mr. Milsom was esteemed by all who knew him. Many charitable institutions in Bermondsey will miss his contributions, so freely given in response to genuine appeals. Many an old Guy's man has cause to remember the many unobtrusive kindnesses he did. They will join with us in our expression of sympathy to Mrs. Milsom and her family in their bereavement. —Yours etc.,

W.G.

The Parasitic Theory of Tumours.

An Address read before the Physical Society by R. LEDLIE, M.R.C.S., L.R.C.P.

1. DEFINITION OF WORD TUMOUR.

The first point one would like to make clear is the meaning of the term "tumours" as used in this paper; the word was originally applied to a vast collection of pathological conditions characterised by the appearance of a localised swelling or lump in the body. As our knowledge of the cause and pathology of some of these conditions has increased, many of them have been excluded from this group, and the word is now restricted to a heterogeneous group of conditions whose pathology still remains a mystery.

Many attempts have been and still are being made to define the term tumour as used at the present time. Let us review some of these and consider in what way they are lacking. An old definition runs as follows: "A tumour is an atypical new formation which is not the result of an inflammation." Powell White's definition is: "A mass of cells, tissues or organs present in the body, but arranged atypically, which grow at the expense of the organism without subserving any useful purpose therein." In both of these definitions we find the use of the term atypical. If this refers to microscopical appearance, as I take it to do, then how do these authors include some of the innocent tumours, whose structure is sometimes identical with that of normal tissue? Mallory's definition, avoiding this word atypical, is: "A new formation (usually a more or less circumscribed collection) of cells, which proliferate continuously and without control: tend to differentiate as *the cells from which they grow* would do under normal conditions; serve no useful purpose: lack an orderly structural arrangement and have, at least at the present time, no assignable cause for their existence." Although a good attempt, it fails in that some tumours do not proliferate continuously (fibroids) and others have a very orderly structural arrangement (adenoma, papilloma).

Having attempted to show why the above are unsatisfactory, it is necessary to put forward a somewhat better one: "A tumour is a new formation in the body, the cells of which fail to obey the laws which govern the growth of normal tissues and cells." This may at first seem a vague definition, but when one examines the question in more detail we find that these laws are very rigid. As the result of ages of evolution the form and size of each cell of the body, the shape, size and architecture of each organ, and the size of the whole organism

itself have been laid down. In addition, each cell has acquired the power of re-acting to external injurious influences, and, more than this, when their object is attained, they endeavour to restore as quickly as possible the form, and relations to each other, which have been established by evolution and found most fitted for the survival of the organism.

Of these laws, the one transgressed most often by tumours is the failure in practically every case of the cells composing them ever to restore the normal form and relations of the body: in other words, once a tumour, always a tumour. And yet, in a few cases of what we regard as tumours, such as the common papilloma of the skin, or wart, we find the cells obeying this law and returning to a perfectly normal condition. I believe there are authentic cases of this also occurring in other tumours, and therefore our definition does not always hold, and it is possible to say, at least in some cases, that tumour cells do obey the above laws. They are, therefore, normal cells temporarily reacting in an abnormal way, and in some rare cases capable of returning to their normal state. Unfortunately, in the majority of cases the cells do not regain this power, and in advancing the parasitic theory I regard these tumours as a failure on the part of the cells to destroy the infecting organism.

2. REVIEW OF OTHER THEORIES.

I will now proceed to review briefly the various theories, including the parasitic, which have been put forward to explain the occurrence and phenomena exhibited by tumours.

(a) *Theories of Equilibrium of Tissues.*

One of the oldest is that of *Thiersch*, who maintained that, in the case of cancer, at least, the energy of growth of the connective tissue failed, and in the later decades of life allowed the epithelium to grow at will, and invade it.

Waldeyer suggested the reverse, that the failure of the epithelial cells allowed the connective tissue to surround and isolate some cells, which then grew uncontrolled in their new situation.

Cohnheim proposed a modified version of a theory first brought forward by Durante in 1874, to the effect that since certain tumours, occurring congenitally, are traceable to maldevelopment, it is probable that all tumours are caused by a similar misplacement of cells during embryonic growth: these cells, possessed of various potential powers of growth, remain latent until some future time, when they suddenly commence to reassume these powers, and proceed to grow. If this theory is true, why do these cells remain latent for so long a time and what causes them to commence growing again? Also we should expect to find growths of different tissues springing up in other organs; for example, a carcinoma commencing in bone. We know, however, that such a thing never occurs.

On the other hand, most of us are convinced that certain conditions usually classified under the heading of "tumours" are undoubtedly due to fœtal inclusion. I refer, of course, to the teratomata of various kinds, and would like to point out here that these growths differ in many ways from the rest of the group: they occur in sites where fusion and infolding of various layers have occurred during fœtal life: they always occur in young individuals, suggesting a congenital origin: they obey throughout the whole of their existence the laws which govern normal tissue growth and mature in the same way, their growth ceasing when the individual reaches adult life. In some cases, one particular tissue may behave like a true tumour and this I would suggest is due to the same cause which operates ordinary tumours, acting in addition.

Ribbert's theory states that tumours are due to the isolation of a group of cells of any particular tissue: this occurs most often in embryonic life but may also occur in adults. It is brought about by abnormal processes of growth of the tissues surrounding these cells. The result on the isolated cells, provided the conditions for development, nutrition, etc., are favourable, is to allow them to exert their capacities for growth unchecked by the normal restraining influences of other cells.

The chief objection to this theory is that it fails to provide us with any explanation for the enormous variation we find in the powers of growth of the tumour cells of any individual organ. For example, in the breast we find every grade between the benign adenoma, the cells of which are dividing very slowly and growth of the tumour is correspondingly slow, and the malignant encephaloid carcinoma, the cells of which are proliferating with extraordinary rapidity. In each case the tumour has arisen, according to Ribbert, from isolated cells of the mammary acini which are exerting unchecked their powers of growth. Why, then, should they in one case divide so slowly and in the other with such rapidity?

(b) *Theories depending upon changes in the cell. Biological or Reproductive theory*: founded mainly on the work of Farmer, Moore and Walker, depends upon the resemblance in the types of mitosis found in malignant cells to those of reproductive cells. In the latter, and sometimes in the former, the chromosomes, instead of having the usual V shape and being arranged at right angles to the spindle, as in normal somatic cells, are thicker, split transversely, and are arranged longitudinally in the spindle. Further, in these heterotypical mitoses, the number of chromosomes is half the usual. On this evidence alone the above observers regard the malignant process as being due to conversion of somatic cells into those of a reproductive type. Many observers have failed to verify these observations in malignant cells, and this theory can, of course, only

be applied to malignant tumours, since these changes are never found in innocent growths.

Lastly, there is the *habit of growth theory* of Adami: he points out that in every cell in the body there are two processes through which the available energy may be expended, (1) function, (2) growth and division. In the normal adult stage all the energy is used in performance of the former. Under certain conditions, which he fails to define, function may be impaired and the energy received is used for growth and proliferation. We might almost agree with Professor Adami if only he would carry his theory a stage further and state that, just as in ordinary processes of inflammation, we find the connective tissue cells and blood cells multiplying in response to the injurious substances injected into the organism, so in the case of tumours we should expect this change to occur in response to the attack of some intracellular organism.

Parasitic Theory.

This theory, the oldest of all, was, I am led to understand on no less an authority than that of Sir H. Morris, first propounded in modern times about the time of Koch's brilliant researches in 1882 on tuberculosis and the establishment of the casual relationship of the bacillus tuberculosis to that disease.

From that time onward, many observers have maintained that they have discovered the cause of tumours, but none have succeeded in establishing their claim. I will not weary you with their names: suffice it to say that among them are such well-known observers as Metchnikoff, Plimmer, V. Leyden, and Doyen. Bacteria of various kinds, protozoa, particularly of the order coccidia, and yeasts, have all been called upon to play this rôle, and I think one of the reasons this theory has fallen into disrepute with the present age of pathologists is the never-ending list of failures in this connection. The theory, as it stands at the present time, states that many, if not most, of the conditions which we term tumours are due to the invasion of the affected cells by an intracellular parasite which produces a toxin capable of inducing cell division. That all tumours are due to one particular type of parasite is not inferred; probably, as in the case of ordinary infection, we shall find a variety of organisms possessed of pathogenic powers.

What evidence do we find in favour of this hypothesis? Let us consider first the various factors concerned in the incidence of growths and see how they accord with it.

There is no doubt that, in the case of cancer at any rate, there has been a considerable increase in the last 50 years. In England, in 1840, the proportion of deaths from cancer to the general mortality was 1 in 129; in 1905 it was 1 in 17. Statistics such as these are notoriously unreliable, but in spite of improved diagnosis and increased longevity we must, I think, assume a definite increase.

To what, then, is this due? Are we to assume that the cells of the body are adopting the Bolshevik tactics of modern times and vying with each other in exterminating the structure which has taken countless generations in its evolution, thereby signing their own death warrant? If not, then this increase must be attributed to the increased potency of some extraneous factor, and could be well accounted for by the increase in pathogenic power of some organism.

Next, as to the incidence in various localities. Tumours are relatively more common in the temperate zones of the universe; in other words, in those parts where the population is densest and infection favoured. Borrel has brought forward evidence showing that tumours are far commoner in mice kept in cages previously inhabited by cancerous mice than in those kept in ordinary cages: the proportion may rise as high as 10 per cent. as compared with 1 in 2,500.

Cancer Districts.

Numerous attempts have been made to associate any local increase of cancer with some peculiarity of the locality. Of these, one of the most reliable is that of Haviland in 1892, who pointed out that in examining statistics one was impressed by the large number of cases in low-lying districts, where the sub-soil was moist, and there was difficulty in disposing of sewerage. Very interesting in this connection is the evidence of Behla. He was for many years an inhabitant of the small agricultural town of Luckau. During the period of observation, 1875 to 1898, the population of 5,000 remained practically unchanged. 3,000 of these lived in the central part of the town, 1,000 in each of the suburbs, eastern and western. During this period, the mortality from cancer was 1 in 25 in the entire town, 1 in 9 for the eastern suburb, and not a single case occurred in the western suburb. All the houses of the town and suburbs were of a similar size, and inclined to be damp. The town and eastern suburb were low-lying, with a moist soil, whereas the western suburb was elevated, possessing a dry, sandy soil. Encircling the town and eastern suburb, but avoiding the western, was a large ditch containing foul, stagnant water. Behla found that most of the cases in the town occurred in houses bordering on this ditch, while all those in the eastern suburb were in houses whose gardens were watered from it.

Many observations have been made on the frequency of cancer in certain houses. How reliable they are, I am unable to state, but I should like to quote Brand's experience. In one house in his practice there were three cases of cancer in succession. All the patients were females, and each was dead within

a year of living in one particular room. The last two had previously lived for some years in other rooms in the house. He states further that after destruction of the bedding and disinfection of the room there were no further cases in the house, at least for some years. This may have been pure coincidence, but is certainly a very interesting experience.

The *site of the primary lesion* is a point of considerable importance. Here we can trace a definite parallelism between the frequency of primary tumours and degree of exposure of the part to infection. It has been stated that 55 per cent. of primary carcinomata occur in the alimentary tract, that part of the body most constantly exposed to infection. In the alimentary canal we find certain parts more commonly attacked than others. The mouth, for example, teeming with micro-organisms, is very frequently attacked, the œsophagus less so owing to the short interval in which the food material is in contact with the mucosa. In the stomach we find carcinoma very common indeed, and generally associated with preceding catarrh or definite ulceration—conditions which would allow micro-organisms to gain a foothold with greater ease than normally. In the small gut, through which the contents are hurried and infection at a minimum, we find tumour formation a comparative rarity. In the large bowel, on the other hand, where the passage of contents is sluggish and multiplication of micro-organisms at a maximum, tumours are again very common.

And not only are tumours much more frequent in some portions of the alimentary canal than others, but also we find in each of these parts certain "seats of election." In the mouth, for example, the tongue is most frequently attacked, particularly in the presence of fissures; the gums, especially round the tooth sockets, are also a common source of tumour formation. In the œsophagus the parts usually attacked are the upper and lower ends and where the left bronchus crosses it; in the stomach, the pyloric region. In the large intestine we find the hepatic and splenic flexures and the sigmoid loop most commonly affected, excepting, of course, the rectum and anal canal, which undoubtedly occupy the premier position in this respect compared with other portions of the lower bowel.

These situations represent, with two notable exceptions, those portions of the gut which are submitted to more friction than the remainder; the very regions where we should expect tumours to occur were they due to infection of the mucosa. The two exceptions are the duodeno-jejunal flexure and the ileo-colic region, in both of which new growths are a distinct rarity; but in these regions, we must remember, as contrasted with the remainder, the contents are considerably more fluid and growth of micro-organisms is at a minimum.

Contrast the common occurrence of tumours in the above regions with their rarity in an organ such as the liver. The cells of the liver are capable of very active regenerative changes, and combine with this a high degree of functional activity. These facts should, according to the tissue tension theories, render that organ prone to primary growths; and yet, even innocent growths, with the exception of angeiomata (a condition not now regarded as truly neoplastic), are pathological curiosities. Primary malignant growths are also very rare, and, when they do occur, are most frequently carcinomata of the hepatic ducts—in other words, that part of the organ most exposed to infection from the gut.

Similarly, in a general survey of the whole body, we find that growths are far commoner in the external parts, including, of course, the alimentary canal, than in the internal organs; compare their frequency in the skin and its adnexa, mouth, intestine and urinary passages, with their rarity in the brain, cord, liver, spleen, heart, great vessels, muscles and joints.

By far the most important etiological factor in growths at present known is that of *chronic irritation*. So well is this recognised that many conditions are referred to as the "precancerous stage." We are all of us familiar with the frequency with which epithelioma of the tongue is associated with preceding syphilis, especially when combined with spirits and smoking. Similarly, we recognise that prolonged irritation from a carious tooth may produce the same condition in a non-syphilitic tongue. There are many other examples, such as the lip cancer of clay pipe smokers, carcinoma of the penis in cases of phimosis, cases of cancer in the gall bladder, renal pelvis, and urinary bladder in connection with stone formation, the occupational cancers, paraffin, tar and chimneysweep's cancer, carcinoma of the kidney and bladder in aniline workers, pulmonary cancer of metal workers and those engaged in cigar factories.

Similar to these are the cases of carcinoma supervening on the basis of chronic eczema (Paget's) and of ulceration (ulcers of the leg, gastric ulcer), in fistulæ and scars, in chronic syphilis and tubercle of the skin.

When we review the tumours of mesoblastic tissues, we find this factor less in evidence; the reason for this being, I think, our inability to follow out the processes occurring in these tissues prior to the development of tumours in them. The same difficulty is met with in the known infections, such as osteomyelitis. We attempt to explain the occurrence of this condition in certain parts of the osseous system by maintaining that these parts have a lowered resistance owing to their structural peculiarities. Why then should we not assume the same factors in

the case of growths of bone which occur far more commonly in these situations than elsewhere.

Perhaps the best illustration of this factor in the connective tissues is to be found in the case of the fibromata. These growths occur more commonly in the mouth than in any other region, presenting every transition between the benign pedunculated fibrous epulis to the malignant infiltrating sarcoma. They arise most frequently in the region of a carious tooth, springing from the tissues surrounding its septic root cavity. This association is indeed so common that some authorities definitely regard the fibrous epulis itself as inflammatory, but deny a similar origin to those forms in which the proliferation of cells occurs more rapidly.

How, then, are we to explain this frequent association of chronic irritation and growth formation. That the latter is not a direct result of the former, as Ribbert and others would have us believe, is, I think, obvious when we consider the large percentage of cases in which chronic irritation is present without being followed by growth formation. This would seem to indicate that, given the condition of chronic irritation, some other factor is necessary before tumour formation occurs. What is more reasonable than to suppose that, as a result of the constant insults to which the affected cells are subjected, their resistance is lowered, and that this paves the way for infection.

The bulk of evidence in favour of the parasitic theory is to be found in the inoculation experiments that have been performed in the last 40 years. Many cases have been reported of auto-inoculation in the human being, from lip to lip, from tongue to gum, and from one labium majus to the other. This occurrence is, however, so rare as to be of no value. I should like to mention here those interesting cases of "Cancer à deux" which have been recorded. Guelliot collected 103 cases in which carcinoma of the penis, identical microscopically with their partner's growth, occurred in husbands whose wives were suffering from carcinoma of the cervix uteri. These are, I think, clear cases of actual transplantation of tumour cells from one individual to another, and their rarity would seem to indicate that some other factor is necessary in most cases before such growth shall be successful.

(To be continued.)

Pass List.

University of Cambridge.

D.P.H., APRIL, 1920.

V. F. Soothill.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES—EASTER TERM, 1920.

PART II.

PHARMACOLOGY AND GENERAL PATHOLOGY.

P. J. Briggs (Christs).

Reviews.

A Manual of Physics. By J. A. Crowther, Sc.D. (Messrs. Frowde, Hodder & Stoughton); price 12s. 6d.

We have read Dr. Crowther's "Manual of Physics," which is written more particularly with a view to the needs of first-year medical students, with a good deal of pleasure. The book is readable and well illustrated, and, emanating from the Cavendish Laboratory at Cambridge, the soundness of the teaching is beyond question. As a rule the medical student does not take kindly to physics, partly because it is essentially mathematical and partly because he generally feels that it will be of no use to him subsequently. We think that such subjects as he will encounter afterwards should be emphasised, and are therefore surprised to find no mention of the processes of diffusion and osmosis. Furthermore, in view of the importance of electrical treatment, it would be well to deal more fully with the subject of electrolysis. For the special purpose in view, it is the best book we have read.

Aids to Electro Therapeutics. By J. Magnus Redding, F.R.C.S.. (Messrs. Ballière, Tindall & Cox); price 5s. net.

Mr. Redding's work at Guy's is too well known to need any commendation here. In his "Aids to Electro Therapeutics," a subject difficult to explain briefly, has been dealt with in a concise manner, and considerable judgment has been displayed in the choice of what is necessary and what is superfluous. It is inevitable that the part devoted to practical details should be considerably condensed. The book will appeal particularly to the general practitioner who wishes to keep abreast of the development in the use of electricity as applied to disease.

An Atlas of the Primary and Cutaneous Lesions of Acquired Syphilis in the Male. By Charles F. White, O.B.E., M.B., and W. Herbert Brown, M.D. (Messrs. John Bale, Sons, and Danielsson, Ltd., 1920); price 27s. 6d.

We agree with the opinion, expressed by Lieut.-General Sir T. H. J. C. Goodwin in his foreword, that this atlas "should prove of more than considerable service to practitioners as an aid to diagnosis." Most of the photographs contained in it are stereoscopic, and this adds materially to their value. There are also four good coloured plates. Apart, however, from the photographs and plates, descriptions are given of the various types of primary chancres, soft sores, secondary and tertiary eruptions, and of certain common skin diseases, e.g., psoriasis and pityriasis rosea, which may be, and often are, mistaken for syphilis. The classification of primary sores, adopted by the authors, is admittedly artificial, for it is based partly on their clinical appearances and partly on their situation (meatal, and intra-urethral, for example). It is of interest that, out of 9,000 primary sores analysed, the so-called Hunterian chancre occurred in only

13·45 per cent., but by many what the authors describe as the "papulo-erosive sore" would doubtless be included under this heading. Out of 19,000 cases of syphilis examined, extragenital chancres were found in 131, and of these 78 were on the lips, but it is pointed out that extragenital sores are commoner in women, and that many cases of secondary syphilis, in which no trace of primary sore can be discovered, are probably examples of extragenital infection. The danger of diagnosing "soft-sore" is rightly insisted upon, not only because a syphilitic sore is often "soft," but because a typical chancroid may at a later stage become a true chancre. In fact, it should be the rule to consider every venereal sore as potentially syphilitic. We recommend this book both to the student and practitioner, and its appearance is opportune, since the importance of an accurate and early diagnosis of syphilis is at last being realised. Such quoted phrases (their origin is not stated) as "illusive (sic) pale spirochæte" and "induration does not constitute syphilis but syphilis constitutes induration," the meaning of which, we confess, is beyond our understanding, in no way detract from the value of the work.

Electric Ionization. By A. R. Friel, M.A., M.D., F.R.C.S.I. (Messrs. John Wright & Sons, Ltd.); price 6s. net.

In "Electric Ionization," by Dr. Friel, there is a good account of the theory of the subject, which is illustrated by simple but clear diagrams. The clinical part of the book is less satisfactory. Impetigo, eczema of the auricle, sycosis, ringworm, and affections of the eye are among the diseases mentioned as suitable for ionization. There is not a particle of evidence to show that ringworm is ever cured by ionization, in spite of all the elaborate and prolonged attempts that have been made, and there is very little reason to suppose that the other diseases mentioned are any more susceptible to this form of treatment. The description of the treatment of ozæma, pyorrhœa, and suppuration of the nasal sinuses, as well as the paragraphs on gynæcology, are very fair.

Diathermy in Medical and Surgical Practice. By Claude Saberton, M.D. (Messrs. Cassell); price 7s. 6d. net.

We believe that "Diathermy," by Dr. Saberton, is the first book in English to be entirely devoted to this subject. It is refreshing to find in a work of this type that more attention is paid to the clinical than the physical side of the subject; at the same time, we think that the chapters on the physics of the subject might with advantage have been fuller. Clinically the author is well up in the literature of the subject. The chapter on Surgical Diathermy, which is in a more advanced stage than medical diathermy, is excellent, and may safely be recommended. There is reason to hope that the diathermy machine, which is really a cautery, and a very efficient and easily regulated one, will soon be made so simple to work that surgeons will use it as a matter of routine in every operation for cancer.

Athletic Sports.

Arrangements for the Athletic Sports, which are being held at Honor Oak Park on Saturday, May 29th, are now complete, and everything points to them being unusually successful. Mrs. Eason has promised to distribute the prizes, the band of the Metropolitan Police, "R" Division, has been engaged to play throughout the afternoon, and tea and ices will be obtainable on the ground.

The entries, compared with those of pre-war sports, constitute a record, and it only remains for every Guy's man to be present on the day with his friends to make the sports the most successful social gathering of the Hospital year.

Tickets are being sent to all the members of the Staff, and entrance to the ground will be free to all members of the Clubs' Union. To others the price of admission is 1s. 6d.

The collection of Inter-Hospital trophies in the College smoking-room is not complete until we have added the Inter-Hospital Athletic Shield, and the athletic section of the Hospital is working hard to capture this. So if you cannot run, turn up on the 29th and encourage those who can, as the keenness of the greatest enthusiast is liable to wane if he is left to feel that nobody minds whether he wins his Hospital, and eventually his Inter-Hospital, event or not.

An attempt is also being made to win the "Rosebery" Cup at the London University Athletic Sports at Herne Hill on Wednesday, 26th instant. Those who wish to cheer on our team can obtain tickets for the stands from R. S. Chambers and L. G. Housden.

Guy's Hospital Rifle Association.

There was a general meeting of this Association on May 3rd. Mr. Thompson presided, and there were about thirty members present. Dr. Ryffel was elected an additional Vice-President.

The ranges are at Bisley, and competitions are held up to one thousand yards range. Mr. G. E. Fulton, a former King's Prize winner, has been engaged as armourer. Rifles are being procured, and are provided by the Club, as well as ammunition.

The Association is affiliated to the N.R.A., and a Donegall bronze badge has been presented by them for competition, the winner being entitled to enter for the Donegall Cup and all money prizes at every succeeding Bisley meeting. The Association is also affiliated to the United Hospitals Rifle Association, and the North London Rifle Club. The latter have a hut at Bisley where meals can be obtained.

Spoon competitions take place once a week, and there will be a prize meeting at the end of the season before the Bisley meeting. Cheap railway vouchers can be obtained from the Secretary.

The Association has to congratulate Mr. S. E. Johnson, the secretary in 1914, on his being selected to shoot for England against Australia.

It is great luck our having such a renowned shot as Mr. Thompson to guide us through this season with all his past Bisley experience.

The Inter-Hospital Competition takes place at Bisley on the same day as and after the Ashburton and Public Schools Veterans competition.

Cricket

GUY'S HOSPITAL v. LONDON HOSPITAL.

Played at Honor Oak Park on Wednesday, May 5th, and won by the Hospital by 42 runs.

Owing to the bad weather we have been unable to hold the usual trial matches this season. The side, therefore, that met London Hospital was composed largely of unknown quantity—only two members of last year's team being included.

Although a low scoring game on a soft wicket, the game served to bring to light a cricketer who will undoubtedly be of great service to Hospital cricket—J. Van Schalkwijk. To clean bowl five men in one over is no mean achievement, especially as he had not bowled on turf before. As a bat, too, he is useful. E. B. Corry and T. J. Williams also played useful innings, but the latter has a lot to learn in "backing up" and running between the wickets. In W. H. Willis we shall have a wicket-keeper of some ability.

Those who have not put their names on the lists or who are unavoidably left out of future trials and are anxious to compete for places in the teams are again reminded that the nets are open on all days when there is not a match in progress, and "official" days are Tuesdays and Thursdays. Unless these men show themselves at nets they cannot expect to be played.

Scores:—

Guy's.

H. A. H. Harris, b Adams	0
J. Van Schalkwijk, c Lindsay b Williams	29
T. J. Williams, run out	1
G. B. Longhurst, b Adams	1
W. H. Willis, b Adams	3
E. B. Corry, not out	40
T. Wooldridge, c Rollston b Swyer	10
R. F. H. Duncan, b Wilder	10
J. C. Rowbotham, c Castle b Wilder	7
Weinberg, c Castle b Wilder	0
L. C. Willis, b Swyer	2
Extras	15
Total	118

London.

Castle, b Schalkwijk	23
Williams, b Schalkwijk	17
Swyer, b Schalkwijk	6
Wilder, b Williams	4
Rollston, b Schalkwijk	0
Adams, b Schalkwijk	0
Vaughan Jones, b Schalkwijk	0
Cathrall, b Schalkwijk	0
Snaith, b Schalkwijk	0
Lindsay, not out	1
King, b Williams	0
Extras	7
Total	58

Guy's bowling: Schalkwijk, 8 for 29; Williams, 2 for 6.

GUY'S v. DULWICH C.C.

Although the ground was in a very bad condition, play was started at 2.45 p.m.; but at 3.15 rain stopped the game for half an hour. It was a disappointing game, and spoilt by rain and drizzle.

F. W. Ellis for the visitors took 6 wickets for 33, and made 35 out of 44 when he was third man out. J. Van Schalkwijk hit well for his 26, and Skeels bowled well.

Scores:—

Guy's.

J. Van Schalkwijk, b Ellis	26
E. H. Muir Smith, c and b Ellis	2
T. Wooldridge, c Robinson, b Ellis	9
L. B. Helder, b Ellis	5
S. Rose, b Proctor	8
G. B. Corry, lbw Ellis	0
H. A. H. Harris, b Ellis	4
R. F. H. Duncan, b Ellis	6
T. J. Williams, b Ellis	13
J. C. Rowbotham, c and b Ellis	0
P. B. Skeels, not out	3
Extras	2
Total	78

Dulwich C.C.

Ellis, b Skeels	35
Bridge, c Rowbotham b Skeels	6
Williams, b Skeels	0
Hoe, b Skeels	3
Hindley, b Schalkwijk	13
James, c Wooldridge b M. Smith	1
Robinson, c Harris b Skeels	19
Tregellis, c Helder b Corry	14
Proctor, run out	13
Gubbins, b Skeels	1
Yong, not out	1
Extras	5
Total	111

Guy's bowling: Schalkwijk, 1 for 37; Skeels, 6 for 23; Muir Smith, 1 for 24; Corry, 1 for 10.

GUY'S 2ND v. BIRKBECK COLLEGE.

Played at Greenford on May 8th, 1920. Guy's batted first on a very slow wicket, which, despite the rain, could not be called good. The batting did not show to advantage, chiefly owing to the eccentricity of the pitch—L. N. Theron making top score with 15. F. R. Payne in taking 8 wickets for 10 runs had the major share in disposing of Birkbeck for 27. Guy's won by 13 runs.

Scores: Guy's, 40; Birkbeck College, 27.

Fixtures.

FIRST ELEVEN.

May 15	Beckenham	Away
„ 19	Practice	Home
„ 22	Sevenoaks	Away
„ 24		
„ 26	Hampstead	Away
„ 29	Bromley	Home

June	2	Southgate	Away
,,	5	Honor Oak	Home
,,	9	R.A.F., Uxbridge	Away
,,	12	Cyphers	Home
,,	16	Sutton	Away
,,	19	Three Counties Asylum	Away
,,	23	Bickley Park (B.P.Wk.)	Away
,,	26	Beddington	Home
,,	30	Dulwich	
July	3	Commercial Union	Home
,,	7		
,,	10	Beckenham	Home
,,	14	Gravesend	Away
,,	17	Honor Oak	Away
,,	21		
,,	22	Cyphers (Cyphers Wk.)	Away
,,	24		
Aug	7	Private Banks	Away

SECOND ELEVEN.

May	15	Beddington 2nd.	Home
,,	19	Practice	
,,	22	Cyphers 2nd	Home
,,	24		
,,	26	St. Dunstan's College	Away
,,	29	Honor Oak 2nd	Away
June	2		
,,	5	University College 2nd	Away
,,	9	Cstl. Area R.A.F. 2nd	Home
,,	12	Private Banks 2nd	Away
,,	16	University College 2nd	Home
,,	19	Dulwich 2nd	Home
,,	23		
,,	26	Beddington 2nd	Away
,,	30		
July	3	Forest Hill 2nd	Away
,,	7		
,,	10	Stondon	Away
,,	14		
,,	17		
,,	31	Cypher's 2nd	Away

THIRD ELEVEN.

May	22	Catford 3rd XI.	Away
,,	26	St. Dunstan's College 2nd ...	Away

The draw for the Cup Ties this year are as follows:—

SENIOR AND JUNIOR.

1st Round.	2nd Round.	Semi-final.	Final.
London } Charing Cross } Bye	Guy's		
"	King's		
"	Middlesex		
"	U.C.H.		
"	St. Thomas's		
"	St. Bart's		
"	St. Mary's		

1st Round to be played by May 31st.
2nd " " June 14th.
Semi-final " " 25th.
Final " " July 12th.

L. B. HELDER,
Hon. Sec. C.C.

Change of Address.

W. G. Beyts, C.B.E., c/o Messrs. Sir C. R. McGrigow Bros. & Co., 39, Panton Street, Haymarket, S.W.

B. H. Daniels, The Birches, Stalham, Norfolk.

J. A. Ryle, M.D., M.R.C.P., Wardens House, Guy's Hospital, and 61, Queen Anne Street, W.1. (Phone Hop. 5300).

I. Tewfik, 16, Kingswood Villas, Gillingham, Kent (Phone 187).

C. T. Helsham, The Norfolk and Norwich Hospital, Norwich.

V. F. Soothill, Westward, The Avenue, Sherborne, Dorset.

Appointments.

N. S. Carruthers, F.R.C.S., to be Hon. Assistant in the Nose, Throat and Ear Department of the Norfolk and Norwich Hospital.

Col. W. G. Beyts, C.B.E., has been appointed A.D.M.S., 6th Division, Cork, Ireland.

V. F. Soothill to be Assistant Medical Officer of Health, Dorset County Council.

C. T. Helsham, Casualty House Surgeon, The Norfolk and Norwich Hospital, Norwich.

J. F. H. Stallman, M.B., B.S., M.R.C.S., L.R.C.P., to be Surgical Registrar to the Hospital for Sick Children, Great Ormond Street.

Births.

DAWSON.—On May 1st, at Ednam House, Willenhall, Staffs., to Dr. and Mrs. R. B. Dawson, a son.

FLOWER.—The wife (née La Touche) of Norman Flower, M.A., M.B., B.Ch., Yeovil, Somerset, of a daughter.

MARSH.—On the 19th April, at 1, Cantelupe Road, Bexhill, the wife of H. E. Marsh, M.C., L.D.S., D.D.S., of a son.

SEYMOUR-PRICE.—On May 9th, at 51, Sloane Gardens, S.W., the wife of Philip Seymour Price, of a son.

TRETHOWAN.—On the 9th May, at 8, St. Thomas' Street, S.E.1., to Mr. and Mrs. W. H. Trethowan, a son (John Durham).

Death.

FAWCUS.—On 18th April, Doris Annie ("Sister Lydia" 1913-14 and previously "Sister Doris"), beloved wife of R. A. Fawcus, at Snowden Cottage, Chard, Somerset.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

A YEAR or two ago there was a good deal of talk about reconstructing the world in a new and better way; men shouted reconstruction from the housetops, but though, in fact, a Ministry of Reconstruction was organised, it soon became evident that, save for the transference of a few of the master cards from the middle to the lower classes, the inevitable reshuffling that followed after the war resulted in the dealing out of the identical "hands" that men held in 1914.

It is not our intention here to elaborate this theme; we mention it because we are now having, in the smaller sphere of Guy's, a demonstration of the methods by which such an unsatisfactory state of affairs may be brought about. It was not unnatural for the members of the Clubs' Union to desire, instead of their small and very unsuitable premises, a more spacious and dignified club; it is not surprising that men should wish to have in place of the arrangements that now exist in the Dining Room of the College, a better cuisine, a more satisfactory service, and cleaner napery on the tables. Accordingly a Sub-Committee was appointed by the Clubs' Union Committee to consider these aspirations. Its suggestion that the management of the Dining Hall should be transferred from the A.B.C. to some other body was rejected by the Council, and its proposals concerning the Pavy Gymnasium were received unfavourably by the Pavy Gymnasium Committee.

It is obvious that if questions affecting the welfare of the Clubs' Union are to be considered and discussed by so many independent bodies of men, the likelihood of a unanimous opinion is small, and the possibility of getting anything done reduced to a minimum. *Advances can only be made by unity of action; it is through the multiplicity of councils, committees, sub-committees, and advisory bodies that progress is obstructed and the well-laid plans of men are brought to nought.*

ON Presentation Day, at the Albert Hall, the Vice-Chancellor of London University, Dr. Russel-Wells, read a letter from the Minister of Education, annoucing that the Government proposed acquiring a site of eleven and a half acres (situated in the neighbourhood of the British Museum), which they intended to offer to the University. Mr. Fisher regretted that, owing to the economic situation, they were un-

able to include in their offer funds to set up buildings as well. The announcement has, of course, created great interest in all the Schools of the University.

It has long been appreciated that London University has never enjoyed that inter-collegiate life, which plays so essential a part in the work of such an institution.

On the offered site, we think, magnificent buildings might be set up right in the centre of the town, comprising administrative establishments, halls for inter-collegiate lectures, and laboratories for organised research work. The opportunity could be taken to house the much discussed University of London Club, with residential facilities, libraries, reading rooms and club rooms. It could thus act as a centre for the social life of the University, welding together the scattered links of the parent institution.

This is a great opportunity; but whether the millions that this scheme would require might not be better devoted to endowing Professorships and extending the existing Colleges of the University, it is not in our province to discuss. We await with great interest the decision of the Senate.

Dr. ABRAMS, in the *Lancet* of March 6th, and Sir James Barr, on May 22nd, have published interesting articles on the subject of "Topographical Percussion."

They consider that in percussing patients, the latter should be "earthed" on copper plates, facing due west and with the limbs apart to prevent short-circuiting. By this method apparently "in cases of cancer, no matter where situated, when the patient is earthed as before directed, let him place his left hand on his right shoulder, and hold his right arm away from the body, when there will be found an oval area of impaired percussion three inches long by two inches wide in the left interscapular area . . . as the polarity of cancer is positive this dull area disappears when the patient faces south and returns when he again faces west."

We are told, too, that "no one ever did, or ever could, become a skilful auscultator who uses that abominable spring contraption called a binaural stethoscope."

The latter statement is obviously incorrect. The great majority of medical men use the binaural stethoscope extensively; it is certainly of more general service than any old-fangled or new-fangled device on the market, and in the hands of skilled clinicians, gives sufficiently accurate results to justify its use.

Secondly, the sound physician can draw deductions from careful percussion when his patient is *not* "earthed," and when he faces north, south, or even due east.

If there is any truth in Dr. Abram's methods of percussion, why are they not more generally known? If, as seems very probable, they are merely the products of a highly imaginative mind, why are these theories printed in an eminently respectable medical journal? We have stated the case at length in order to elicit the opinion of those who are at all interested in these fascinating conceptions.

WE regret to announce the death of Col. E. Roberts on the 20th May, 1920. He was associated with Guy's during the latter part of the war, at a time when qualified practitioners were scarce, and the difficulties of carrying on in many departments of the Hospital were great.

Had it not been for Col. Roberts' assistance in Children's Out-Patients, the work of that important department would certainly have suffered. He realised that the first duty of the medical man is to help in the conservation of infant life, and accordingly devoted himself to the work with the greatest keenness and enthusiasm.

In Out-Patients he spared no pains to impress on the mothers every detail that was necessary in the treatment of their sick children. Where many a man would have given up in despair, Dr. Roberts would explain again and again what a child should eat and how it should be fed; how necessary it was to keep windows open—even at nights, meeting the incredulous look with arguments, that even the most ignorant mother could understand.

The Salomons' Centre also owed much to Dr. Roberts' interest and advice. In memory of his wife he had, shortly before his death, presented a sum of money, the income of which—about £150—is to be devoted to some purpose connected with the Centre.

Pass List.

Society of Apothecaries of London.

FINAL EXAMINATION, APRIL, 1920.

Surgery.

C. C. Bennett (Section I.).

Midwifery.

A. McKenzie. W. H. Summerskill.

L.D.S.

FIRST PROFESSIONAL EXAMINATION, APRIL, 1920.

W. O. Bailey.
C. V. T. Baugh.
E. C. Bevis.
J. H. Broadhead.
J. H. R. Creasy.
D. J. du Buisson.
J. S. de V. du Toit.
L. W. Elmer.
F. J. Farmer.
F. C. Gardenner.
W. M. K. Gray.
G. T. Hankey.
W. R. Hibbins.
F. R. Hogbin.
J. N. Human.
J. Lanchester.
S. Levinson.
H. J. Luck.
J. C. Faure.
E. C. Packham.
O. F. R. Painter.
G. Parker.
G. Pengelly.
G. P. Pritchard.
S. H. Rands.
J. H. Reid.
J. D. P. Roberts.
H. G. Ryder.
J. D. P. Ryder.
E. H. L. Sander.
H. V. R. Sellers.
J. S. Smith.
D. J. Stofberg.
W. G. Strickland.
P. G. Trafford.
A. K. Van Niekerk.
T. E. Withers.
F. W. Watt.

MECHANICAL DENTISTRY ONLY.

R. C. May.
D. J. Baker.
T. R. Churchill.
A. Clarke.
D. M. Desai.
C. H. Edney.
F. J. Fourie.
S. P. Meacock.
F. A. Meyer.
O. G. Morris.
S. D. Neal.
R. Schofield.
G. L. Shearer.
L. N. Theron.
G. S. W. Willis.

DENTAL METALLURGY ONLY.

I. Broude.
L. S. Carter.
G. Beamish.
A. B. Daneel.
J. I. de Villiers.
C. D. Farris.
A. S. T. Garland.
W. E. Silver.
H. Slater.
C. R. Hardwick.
G. G. T. Haynes.
L. B. Helder.
S. T. Hine.
K. Hooper.
F. C. Hutchinson.
E. J. Joel.
V. L. Sunderland.
F. W. Van der Hoven.
J. E. Jones.
G. B. Kempster.
B. J. M. Keyter.
R. V. Koenig.
S. Macey.
D. W. C. Northfield.
W. J. Olivier.
H. J. Raubenheimer.
M. Patlansky.
C. M. A. Pauw.
H. H. Pickett.
P. Pienaar.
J. F. Pilbeam.
B. Rubinstein.
E. Samuels.
R. Schlimmer.

Conjoint Board.

FINAL EXAMINATION, APRIL, 1920.

Medicine.

F. W. Crook.
H. A. Crowther.
W. D. Doherty.
P. Couacoud.
G. I. C. Gill.

Surgery.

D. J. P. O'Meara.
*W. M. Brown.
*T. Reed.
*R. W. Warrick.

*Denotes completion of examination.

Midwifery.

W. D. Doherty.
E. T. Lloyd.
G. I. E. Gill.
D. J. P. O'Meara.
E. J. Crisp.

The Differential Diagnosis of Some Continued Fevers.

CLINICAL LECTURE BY H. C. CAMERON, M.D.

GENTLEMEN,—I want you to imagine you are standing by the bedside of a patient suffering from continued pyrexia of unexplained origin. Of course, there are many causes of continued pyrexia which a careful physical examination may detect, but there are at least four comparatively common disorders which are apt to present themselves as, in the first instance, cases of continued pyrexia the cause of which is obscure. I propose to discuss the differential diagnosis between these.

TYPHOID FEVER.

The first is Typhoid Fever, a difficult disease to diagnose, if you meet the patient for the first time in the first or second week of the illness and there is no information available as to the course of the disease up to that point. On the other hand, if we are able to watch the disease progress and to follow the changing phases of the illness, we can, in nearly all cases, make an absolutely confident diagnosis. There are, perhaps, five different phases through which an ordinary case of typhoid fever passes: (1) The first week is characterised by a slowly ascending, step-like rise of temperature. Typhoid Fever is a disease of slow onset. Contrast it in this respect with such a disease as pneumonia or influenza. A man who is suffering from influenzal pneumonia may be able to tell you precisely what he was doing at the moment of onset. In Typhoid Fever you will often find that work is given up gradually. For a day or two the patient may have felt unwell. He stays at home from work on one day and makes an attempt to return on the next. It is often several days or even a week before he finally takes to bed. In the early stage of typhoid fever the pulse is slow, perhaps not more than 80, although the temperature is as high as 103°F. As the disease progresses, the disparity between pulse and temperature tends to disappear. This pulse and temperature ratio is of great importance in differentiating typhoid fever from, for instance, infective endocarditis. Otherwise, in the first week the complaint is mainly of headache; often there is epistaxis; the pulse is said to be dicrotic. (2) It is in the second week that the disease takes on an abdominal aspect; that we meet with constipation, or, less commonly, with diarrhœa; that there begins to be apparent a certain tumidity, or even a tympanitic distension of the abdomen. Sometimes there is complaint of abdominal pain and tenderness. In the second week, too, the spleen generally begins to be palpable, and early in the second week the typical rash of typhoid fever appears. Each individual spot, perhaps, is not very characteristic. I suppose that if you or I searched every inch of our skin with the same care that we search the skin of a suspected case for typhoid spots, we might find here and there a papule which might seem to have much the appearance of the rose-coloured lenticular spot characteristic of the disease. And the rash of typhoid fever is very sparse. There may not be more than half a dozen spots visible. Each one of the spots may present nothing absolutely characteristic: it is the appearance at the anticipated time which is important. The spots are most likely to appear on the abdomen, the chest, or on the thighs. They may also appear on the back, but it is chiefly on the back that the presence of other papules is apt to lead to confusion. During the whole of the second week the temperature maintains its height, and, generally, during the third week, too. (3) But the third week is characterised by a new phase. It is in the third week that the Peyer's patches begin to slough, and, therefore, it is in the third week that diarrhœa occurs as a prominent symptom. As a result, it is common to find some hæmorrhage from the bowel, although severe or fatal hæmorrhage is a very rare event. And it is in the third week that another of these rare accidents happens, namely, perforation of the bowel, with general peritonitis. Do not forget that these are comparatively uncommon events: they are the cause of only two per cent. of the fatalities, and the death rate in typhoid fever does not commonly exceed 10 per cent. or 15 per cent. (4) Towards the end of the third week a change takes place in the type of temperature. It begins to fall, but it gets a larger swing. There is at this stage some degree of infection of the blood stream by organisms other than the bacillus typhosus—the bacillus coli communis, for instance—which pass over the ulcerated areas of the bowel, and, as a result, there is a septic type of temperature rising high at night and falling in the morning. (5) The fifth and last

phase is that of relapse or complications such as periostitis, splenic abscess, cholecystitis, and suppuration in the mesenteric glands. If the patient succumbs in the fourth or fifth week, he is likely to die from heart failure, with œdema and hypostatic infection of the lungs.

If we bear these changing phases in mind, it should be possible, sooner or later, to make a diagnosis with certainty.

INFECTIVE ENDOCARDITIS.

Now let us take the case of infective endocarditis, and consider it critically, laying stress on the points in which a case of infective endocarditis with continued fever differs from a case of typhoid fever.

In the first place, the great majority of cases of infective endocarditis which you will meet with will have evidence of long-continued chronic endocarditis, and of old inflammatory lesions in the mitral or aortic valve, and the recent acute infection is superimposed upon the old cicatricial changes in the valves. The number of cases in which you find infective endocarditis attacking valves which were previously healthy is comparatively small. What makes us suspect the development of this fatal acute infection on the top of the old scarring of the valves is perhaps generally, in the first place, pyrexia. The temperature may not be very high, but we have always to pay much attention to pyrexia in cardiac disease, because, as you know, cardiac disease with some degree of heart failure tends to have a subnormal temperature. If you look at the charts of patients who are cyanosed and dyspnœic from chronic heart disease, you will find that the temperature is often below 96°F. A rise to 100°F. then may have here all the significance of a rise to 103°F. In the second place, one is struck by the anæmia of these patients. Their mucous membranes lose colour. With pyrexia and with anæmia a suspicion of infective endocarditis in chronic cardiac disease is aroused. Still, there may be nothing conclusive about these symptoms. I have written up on the board five or six symptoms for which we must always be on the look out, and which if they appear may make the diagnosis certain.

(1) In the first place, there is infarction. Sooner or later it is likely that some part of the soft fungating clot on the mitral or aortic valve will be detached, and, passing into the circulation, impinge in some situation or other, most commonly in the spleen, the kidney and the brain. If there is an infarct in the spleen, that organ may enlarge suddenly, and there may be complaint of pain over it. In some cases there may be a pleuritic rub over the infected spleen. If the clot passes to the middle cerebral artery a sudden hemiplegia is the result, and if it passes to the kidney, a sudden hæmaturia. The amount of blood may be considerable in one micturition, but will pass off within a comparatively short period, differing in that respect from the hæmaturia of acute nephritis, when the urine is permanently tinged with blood.

(2) As important as infarction is the evidence of purpura on the skin; and if you suspect infective endocarditis, you must search carefully for purpura. Hæmorrhagic retinitis, too, is common and very significant, so that examination of the retina is necessary.

(3) The *sudden* appearance of the signs of aortic regurgitation is conclusive of infective endocarditis. There are, perhaps, five common causes of aortic regurgitation: rheumatism, syphilis, atheroma, aneurysm, and infective endocarditis. But each of these produces incapacity of the aortic valve slowly by a process extending over many months, with the exception of infective endocarditis, in which the ulcerative process may eat away the structure of the valve, so that its whole scaffolding may give way in a night. I remember more than one uncertain case in which the condition was diagnosed by the evidence of the sudden establishment of aortic regurgitation.

(4) *Post-mortem* examination shows that probably about 50 per cent. of the cases of infective endocarditis die with glomerular nephritis. We do not see many cases of acute nephritis in the post-mortem room at Guy's, because, of course, we do not admit cases of scarlet fever, but of the cases which do occur, infective endocarditis accounts for the largest number. The kidney is that which was called by Sir Samuel Wilks the "flea-bitten kidney"; the glomeruli, an angry red, stand out on the buff-coloured background of the kidney. If, then, a patient with continued pyrexia suddenly gets blood in the urine, a considerable quantity of albumen, and blood casts, this will strengthen the supposition that infective endocarditis is the cause.

(5) And lastly, there is a very striking and quite diagnostic sign — the appearance very

often on the hands and feet of nodules which rather remind one of rheumatic nodules, although the local reaction is much more severe. The nodules are intensely painful, and are surrounded by a zone of congestion. Often they are overlooked or regarded as merely a local point of sepsis or something which had no connection with the patient's unexplained pyrexia. Yet, if recognised, they make the diagnosis certain. They are described as "multiple, peripheral, painful, ephemeral subcutaneous nodules," and beyond that I think they need no more description.

They are ephemeral because each nodule lasts only for a few days. I have seen many of these cases in the wards, and sometimes the nodules have been the first sign which has enabled us to feel confident about the diagnosis. I think they tend to occur, too, in the most chronic form of infective endocarditis, *i.e.*, cases of no very great malignancy, which, perhaps for that reason, are more difficult to diagnose.

It is worth while to have in mind these possible and very significant developments when you are debating the likelihood of a case being one of infective endocarditis.

MILIARY TUBERCULOSIS.

Miliary tuberculosis is the third common condition which is apt to present itself as an illness marked by persistently high temperature and by nothing else. As a rule, the general dissemination of the tubercle bacillus all over the body is preceded by a certain period of illhealth during which the tuberculous infection remained local, possibly in a caseous gland in one situation or another. During this time there will be indefinite illhealth, with loss of weight, and loss of vigour. With the onset of the general miliary tuberculosis the temperature rises, and the severity of the illness becomes increasingly apparent.

(1) In some cases the signs and symptoms of tuberculous meningitis develop early and make clear the nature of the disturbance. If meningitis does not supervene, there may be some weeks of high temperature without any characteristic sign or symptom.

(2) We must examine the retina for the presence of visible miliary tubercles—not a very frequent occurrence, it is true, but one which should not be overlooked. In young infants they occur unusually often, in older children and adults more rarely.

(3) Upon the skin I am able to show you from time to time an eruption which tells us that there are caseous tuberculous masses somewhere or other in the body—the so-called papulo-necrotic tuberculide. Scattered over the skin of trunk and limbs are numerous minute papules each of which rapidly undergoes necrotic and cicatricial changes in its central part, so that the centre part of each papule is depressed.

(4) Sometimes we may suspect the truth from noticing the rapid respiration rate and a degree of dyspnœa which is not accounted for by any physical signs which can be demonstrated in the lungs or in the heart. The lungs may be stuffed full of miliary tubercles, closely crowded together, and yet the physical signs apparent may be very slight, amounting to no more than crepitations due to the increased fluid content of the lung. An increased respiration rate is always suspicious.

(5) As a rule, the spleen is enlarged, as it is indeed in typhoid fever and in infective endocarditis. Sometimes, though by no means always, it is very greatly enlarged by caseating tubercles of large size, and it is then much harder than in the spleen in typhoid fever or infective endocarditis.

(6) It is said that in miliary tuberculosis the temperature chart is often reversed, the highest mark being in the early morning, the lowest at 6 p.m.

PYELO-CYSTITIS ; BACILLUS COLI COMMUNIS INFECTION.

The fourth condition which I have set out to discuss differs from the first three in that from the first there is a positive indication of the nature of the disease in the urine. The changes in the urine, however, may be quite slight and may need to be searched for carefully. There may be the merest trace of albumen or even none at all. The urine is not turbid, at the most it may be said to be opalescent, and there may be no macroscopic evidence of pus. Examination of the centrifugalised deposit, however, shows a definite excess of leucocytes, and cultivation of a catheter specimen of urine shows the presence of the bacillus coli communis. Slight as these changes may be, they are able to account for pyrexial attacks of long duration. Infection of the urinary tract with bacillus coli communis is common in female infants and it is again a common complication of pregnancy after the fifth month. When in-

fection has taken place it is apt to be very persistent. Long after the clinical symptoms have subsided examination of the urine may show the persistence of the same abnormalities, and there is thus always present the possibility of a relapse. In some cases there may be pain and frequency of micturition, or pain and tenderness over a kidney, in pregnancy usually the right kidney, to indicate the nature of the illness, but it is the absence in so many cases of all symptoms other than pyrexia which makes its consideration here necessary. Very often there is not only pyrexia, there are also rigors. In young infants it is almost the only disease in which definite rigors do occur. Rigors do not occur in the early stages of typhoid fever; they are not common in miliary tuberculosis. In infective endocarditis they may be a prominent symptom. In typhoid fever, in the later stages, it is well to remember that bacilluria is the rule and that infection of the pelvis of the kidney is an occasional complication.

Other and Rarer Causes.

These four conditions of continued pyrexia you will meet with often enough. There are a few others of rarer occurrence. In portal pyæmia or pylephlebitis there may be a long period of pyrexia before the occurrence of repeated signs, jaundice, tenderness, and enlargement of the liver, and possibly peritonitis makes the diagnosis plain.

At times the interval between the primary infection with syphilis and the appearance of the secondary rash may be marked by considerable and persistent pyrexia. Lastly, there are some cases of Hodgkin's Disease in which the glands involved are deep-seated, and therefore difficult to detect, which nevertheless show the bouts of pyrexia which are characteristic of the disease.

Appointments.

J. Lewin Payne appointed Lecturer in Dental Surgery, Guy's Hospital, and External Examiner in Dental Subjects to University of Birmingham.

Honours.

O.B.E.

J. Lewin Payne, January, 1920.

The Minesweepers.

Although by the calendar it is little more than a year ago, already the episode has taken on a fantastic quality, so that I have sometimes to pause and ask myself whether or no the interlude was more than a remembered fragment of a vivid dream.

For long enough we all of us had fretted and wilted in the blight that Mudros throws over the bravest. The veterans, those who had paced the same quarter-deck and heard the same jokes for upwards of four years, went through life in a sort of maze. For them the passage of time was marked by the fluctuations of the monthly wine bill—the glorious openhanded freedom of the first week, the nightly sing song in the ward-room, the rough house, the morning liver; the week after, a sufficiency but no extraneous liberalities; the third week, ten bob more to go—!; the fourth week, "Well, I don't care if I am over the fiver!" The passing of the seasons had a secondary importance. To those who know it, the accursed isle of Lemnos will always remain a bitter and one hopes a buried memory. There was something, I know not what, in the prospect of its unchanging barrenness, the harsh grey green rocks, the mean and sterile fields, that had for most people an unbounded quality of exasperation. Unchanging, did I say? Not quite, for on the morning of which I write a touch of spring had softened the asperity. Green grass, brilliant and short-lived, but undeniably green, seemed to have grown almost within the night; the fig trees were putting out fresh buds, the more lovely by contrast with their darker foliage, and in Aegean back yards the almond blossom glowed pure and fresh above the mud and filth. For once, too, the Etesian—that wind that churns the harbour of Mudros into a miniature Atlantic within half an hour—was still, and as I stepped into the boat which was to take me to my floating and unfashionable practice, the Maltese helmsman grinned from ear to ear and wished me "Buon Giorno" with a gallant air. For a brief moment the goddess had laid her finger even on Lemnos, and, though a prison, for an instant the prison walls seemed almost lovely.

Those who know their Mudros, know too the "Europa," that vast four-funnel cruiser, whose destiny it has been well-nigh since her launching to lay swinging at a buoy, a silent tribute to the fallibility of man's judgment. Once, perhaps, she was the pride of the seas, but on her maiden trip her steaming qualities were proved to be so poor that since then no other service could be found for her than to lie in harbour, stranded, as rumour has it, upon a pile of milk and salmon tins, a permanent feature of the landscape. Here she has lain since the early days of Gallipoli, and upon such as dwell in her

was conferred by the irreverent the decoration of the O.B.E.—the Order of the "Europa." A depôt ship is rarely a popular vessel, and in this respect the "Europa" followed the best conventions. Huge and unwieldy, she towered above the small craft around. For all I know she is there yet, whilst upon her quarter-deck, irate captains and commanders imparted the elements of seamanship—per megaphone—to the gallant officers of the Naval Reserve coming alongside in tugs and dinghies.

On my return that February morning, I found a small crowd around the notice board. A small typewritten slip announced "Officers are required for the Aegean Mine Clearance Service. Names should be given in to the Captain's office before noon." It was the Spring, I suppose; there is no other excuse, for within five minutes my name had been inscribed upon a roll, with the ominous comment "I don't suppose they'll *need* any doctors . . . "

. . . . . .

It is so late that it is almost early. A faint sound of cheering reaches us from astern, where the ship I have left rises up like a factory, all her ports agleam, for it has been the last night of the far-famed "Europa's" concert, and that as a rule is a pretty good night. My new captain rests his head upon my shoulder and murmurs "*You* know where she's lying, cox'n." The boat's crew pull wearily and look sullen. Apparently these early morning trips are no novelty . . . . I must have been nodding, for I wake with a start at a terrific sound of barking, see a light ahead, and beneath it a dark mass. The captain opens his eyes and shouts in one breath "Bows!—way 'nough!—oars in!" and then crash! The barking rises to an uproar, and dark agile shapes with gleaming eyes leap on the deck above us. Respectfully I assist the captain on to the gangway, and as he reaches the deck I hear a growl, a curse, and a thud. Evidently the ship's dogs are to be avoided in the small hours.

Later, much later, in his cabin, the captain bids me a tearful goodnight, and, dazzled by the bright sunlight, I make my way aft over the slippery iron decks. My novitiate in the M.C.F. (Mine Clearance Force) has begun.

By day a turn screw sloop, as the sweepers are officially designated, is an unlovely object. A long grey-black hull, encumbered with superstructure, a squat grimy funnel, the quarter-deck a tangled mass of wires, buoys, hawsers and winches, they are pre-eminently ships for hard and unlovely toil, that of clearing the seas that their spit and polish brethren of the fleet may sail the seas in peace. Officered in the main by men of the mercantile marine or volunteer reserve, the relationship of men and officers was remarkable for a *sans facon* which would have provoked dire penalties elsewhere.

To one accustomed to a certain distance, there is at first something disconcerting in being politely asked for a drink in the small hours of the morning by the quartermaster on watch. After a time it loses its pristine horror and becomes merely a manifestation of a charming naturalness.

The operation of sweeping consists in its simplest form of towing a long steel cable between two ships, kept at a suitable depth by means of a prism shaped piece of wood—the kite. Obviously with all working well this proceeding should be straightforward, and, provided proper precautions are taken, almost wthout danger.

The line of mines is first located, generally by means of a kite balloon towed over the suspected area by a light draught vessel, buoys are dropped along its course, any angles of the line being marked with especial care. As soon after as possible the sweepers come out, sweep up the line, the steel cable cutting the moorings and the mine coming to the surface by its own buoyancy, drifters and trawlers following after explode the mines or sink them by rifle fire, the crews collect the fish killed by the explosion, and all is well. In practice a lot of things may happen. The kite, true to its name, may plunge towards the ocean depths in an entirely unrehearsed fashion, more especially if the stoker on the winch has forgotten to brake up properly. The sweep wire may part without apparent cause not once only but time and time again. The marking buoys may, owing to some set of the current, drift, so that instead of being a full fifty yards from the line to be swept up, they are right upon it. They may, moreover, leak and sink, an eventuality causing much heart-burning and bitter words. The sweep wire, having caught a mine, may explode it, thus parting the sweep and giving a nasty jar to the unwary. Bearings may be lost, a small space left unswept, and the whole area has to be re-swept to ensure that no part is left untouched. Mines, again, have a nasty habit of entangling themselves in sweep wire, to be hauled in all unsuspecting—with sudden and disastrous results. The mark boats, whose duty it is to sink the drifting mines, may fail to do so, leaving them afloat, to provide the matelot with vivid reminiscences of the times when "the ruddy mines was that thick you 'ad to push them orf wiv a boat-'ook."

The orderly procession of little ships that steamed southward to the Gulf of Smyrna seemed, in leaving Mudros, to have passed from the promise of Spring to the realization of early summer. True the promontaries we passed—so closely indeed that the shoal water seemed almost to touch our beam—were bare enough save for sandy scrub, but the sky was of that deep and satisfying blue that comes only in the warmer latitudes, and there was in the air a promise of heat to come. Slowly as the bay opened

before us, unnamed upon the chart, known only perhaps by some rough Turkish place-word, the sight of its exquisite beauty seemed to calm for a moment the clamour of the seamen. Picture a long deep estuary that, as one entered, seemed closed all about with hill and mountain, the cliffs in places falling steeply to the water's edge, elsewhere fringed with a verdure of the richest emerald.

At its extremity lay a tiny village of lime whitened cottages nestling among dense foliage, vineyards and olive groves mounted the slopes, the dark green of their leaves offering faint contrast to the grey tones of the limestone cliffs. Near to the shore we dropped anchor, and as the chains rattled in the hawsepipes a shepherd clad in spotless white, with a *Kaftàn* of brilliant crimson appeared on a little knoll scarce a hundred yards distant, and waved his arms at us. A couple of fierce sheep dogs bayed fiercely, awakening echoes from our own home pack. From nowhere in particular, crowds of natives in costumes of remarkable raggedness gathered upon the beach, and a few patriarchs discharged muskets into the air. It was the official welcome of the M.C.F. Long afterwards, under conditions very different to the tranquil scene before us, we should remember this inaugural ceremony.

G.H.F.G.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—As a member of the first Committee of the Club after the College was built, about thirty years ago, I heartily support the suggestion you refer to in the editorial notes of your issue of May 1st.

At that time we were only too thankful to secure a dining, smoking and reading room in the new building to replace the bare ward in Hunt's House which had previously done duty as a club. I remember leading the attack on the catering system we suffered under, at a general meeting called to discuss it, in the Anatomical Theatre. The theatre was crowded with students and Staff, and Sir Alfred Fripp and Dr. Allport, then students, were down to oppose me. As they were men open to conviction, they raised no objections after I had explained my case, and the vote was practically unanimous in favour of a new committee and a new caterer in the new college.

The catering, for all I know, may now be perfect, but the club rooms in the college never have been adequate, nor worthy of a Hospital School like Guy's.

If possible, in any new scheme the kitchen should communicate with the dining room by two doors, one for entry, the other for exit, in the middle of the long side of the dining room, and the students should enter elsewhere. There should be a sufficient lavatory near the students' main entrance to the dining room. The smoking room should not be half under ground, nor the reading room serve as a passage way. It is little use adding a "billiard room" unless an adequate number of tables be provided, otherwise the less skilled players will seldom be other than onlookers.—Faithfully yours,

D. W. SAMWAYS.

Mentone.
May 7th, 1920.

DEAR SIR,—Whilst taking a friend a few days ago over the Museum, it occurred to me that the name of Towne might with advantage be attached to his splendid models, also that the lettering on some of the other specimens, notably the dermatological ones, might well be renovated. Apologising for the criticism, Yours faithfully,

M.

12th May, 1920.

DEAR SIR,—Mr. Fagge's lecture on Circumcision was heartily approved of by a large section of your readers, composed of men either recently qualified or nearly qualified. These men are not as yet hidebound by rule-of-thumb methods, and even in minor surgery like to have a reason for everything they do. When they ask the reason for the performance of many circumcisions, they meet with most unconvincing and illogical replies. Some tell them that the prepuce cannot be retracted, apparently ignoring the fact that this is physiological in infancy; others still seem to consider that it cures enuresis or masturbation, in spite of many proofs to the contrary; others talk vaguely about the prevention of venereal disease, although it is difficult to see how the exposure of a large area of delicate mucous membrane to infection can act as a preventative; again, others, ponderously humorous, say that it is a certain cure for congenital stenosis of the pylorus.

In many cases, I am afraid, your nursing correspondent is right, and it is the extra fee that the doctor gets that is the real reason for many performances of this operation.

If only lovers of this operation would go to the back surgery any day and hear the cries of some ten or twenty little children, screaming with the pain of their dressings, if they have any heart left they would not so glibly recommend this vaunted panacea for all ills to every ignorant Borough mother they see. (I am forbidden to express myself more strongly).—Yours, etc.,

V.B.

DEAR SIR,—At the top of the second column on page 155 of your issue of May 15th, Dr. C. P. Symonds says, "*A routine examination of every suspected case of cerebral tumour should be made to exclude other possibilities. If there is evidence of otitis media past or present, the possibility of abscess must be considered, and the opinion of an otologist obtained.*" I wrote to criticise these sentences the more freely because from a conversation I had with Dr. Symonds shortly before he left for the States I believe that these words misrepresent his true views. To make my meaning clear I will re-write the quotation. "*A routine examination of every suspected case of cerebral tumour should be made. In this way positive evidence may be gained and other possibilities will be excluded. Thus the otologist may help in diagnosing the presence and site of a tumour, and he will give an opinion on the presence or absence of past or present otitis media, and assist in the exclusion of an abscess.*"

No neurologist would dream of approaching a case of suspected cerebral tumour without either acquiring the skill to examine the second cranial nerve or else sending the case to an ophthalmologist; yet I doubt whether many neurologists are competent to make such an examination of the two parts of the eighth nerve, and I am confident that they do not send every case to an otologist. I believe that the only place in London where this is done as a routine measure is the National Hospital in Queen's Square, the otologist to which, Mr. Sidney Scott, has had opportunities of becoming expert in these examinations, which have been withheld from other otologists. At a combined meeting of the Neurological and Otological Sections of the Royal Society of Medicine held in the winter preceding the war a demand for this routine examination was put forward by the otologists, so far without result.

It is remarkable that when a physician or neurologist does ask an otologist to make an examination of a case he always asks for a deduction as a result of the examination, and seems disappointed when this is not forthcoming as though it were not worth while to ask for a similar examination in a future case. This is a wrong stand-point from which such cases should be considered. The otologist merely reports on the functional condition of the acoustic and vestibular nerves, and it is for the physician to correlate this evidence with that obtained from all other sources. No doubt when he has had sufficient experience in this class of case the otologist will be able to give very material assistance in the diagnosis and localisation of intra-cranial tumours. My own belief is that in the future more reliable evidence will be got from the examination of the eighth nerve than from any other single source of evidence, not excepting the second cranial nerve, and that this will particularly be the case in diagnosing whether a tumour is supra-tentorial or sub-tentorial, whether it is cerebellar or extra-cerebellar, and perhaps in the localisation of cerebellar tumours.

But this evidence will not be forthcoming until examinations of the eighth nerve are made in all cases of suspected intra-cranial tumour and not only in those where the diagnosis is already partly made and some gross symptom of the auditory-vestibular systems draws the attention of the physician to the need. It is only by examining those cases in which he can be of no assistance, that the otologist can so check his tests as to be of use in those cases where he may be able to help.

But I would cavil still further at Dr. Symond's phraseology where he suggests that the past or present existence of otitis media should only be referred to the otologist where there is already evidence of it. In a very large number of persons evidence of old otitis media can be found by the otologist where the disease has been quite unknown to the patient, and in an appreciable number of these cases, some active disease is still in progress. For this reason only, every such case should be referred to the otologist, even if he could do no more to assist.

As I have said above, I believe that Dr. Symonds shares my views, and he may say that I have read a meaning into his words which he never intended; but the importance of words lies not in what their writer means but in what the reader may reasonably infer from them. Now the inference that I have made from his words is, I believe, reasonable, and as they will lead, in my opinion, to the spread of false teaching, I will ask for sufficient of your space in which to lodge this, my protest.—I am, dear Mr. Editor, Yours sincerely,

T. B. LAYTON.

10, Welbeck Street, W.1.
May 24th, 1920.

Change of Address.

Dr. W. A. Carden, Lulworth, Eltham, Kent.

S. W. Coffin, 37, Willifield Way, Golders Green, N.W.4. (Phone Finchley 1769), and 30a, Wimpole Street, W.1. (Phone Mayfair 4117).

K. B. Alexander, c/o Standard Bank of South Africa, 10, Clements Lane, E.C.

Capt. W. L. E. Reynolds, M.C., R.A.M.C., from D.A.D.M.S., Embarkation, Dover, to c/o S.N.O., Sierra Leone, West Africa.

W. L. Gwyn Davies, Croylands, 111, Cheriton Road, Folkestone, Kent.

J. F. Young, Germiston, Transvaal.

The Parasitic Theory of Tumours.

An Address read before the Physical Society by R. LEDLIE, M.R.C.S., L.R.C.P.

(*Concluded.*)

Animal inoculation was first carried out by Hanan in rats, followed by Moran and Borrel in 1894 on mice. The former claimed success in 100 per cent. of cases, the latter 10 per cent. In more recent years this work has been carried on by many observers, among whom may be mentioned Bashford, Jensen and Rous. They have succeeded in transplanting tumours through many generations of animals of the same species, and shown conclusively that it is the actual graft which forms the new tumour in the host. The percentage of successes varies with different tumours, but may be considerably increased by repeated transplantation. The rapidity of growth of the tumour may be considerably modified in different individuals, according to age, conditions of health, and variety of animal inoculated.

All these experiments have, however, been performed with actual injections of the tumour substance, containing many cells, and have only gone to prove that tumour cells retain their unlimited powers of division and growth in their new surroundings. They have, however, provided us with a strong argument against any theories regarding equilibrium of tissues, because in the new individual the conditions of tissue tension, etc., are presumably normal, and the tumour cells should, under these conditions, cease growing.

The most important observations that have been made on tumour formation in the last few years are those of Rous, Murphy and their colleagues; to these I should like to refer in greater detail.

Rous was one of the first to draw attention to a new formation in fowls which behaved like the malignant growths of man. Clinically its growth was attended by wasting and cachexia, which finally resulted in death. At post-mortem examination secondary deposits were found in various organs and histologically these and the primary possessed the characters of a spindle-celled sarcoma.

Since that time he has succeeded in transplanting this tumour through 32 successive series of fowls. At first this was done by actual grafts of the original tumour, and it was found that in each successive graft, the percentage of takes was higher than before. Recently he has succeeded in reproducing these tumours by injections of (1) filtrates from the tumour freed from cells by a Berkefeld filter, (2) desiccated extracts, (3) extracts prepared from tumours, the cells of which had been killed by glycerin.

The original tumour was a discrete, fairly encapsuled mass, firm and gristly, consisting mainly of spindle cells and some round cells in the more rapidly growing portions. During the transplantations performed there were noticeable differences in the naked eye and microscopical appearances of the tumour. In some fowls, the growth maintained a somewhat discrete character, whereas in others it took the form of a diffuse, soft mass, often containing numerous hæmorrhages, and spreading more rapidly. Marked changes were also found in the distribution of the metastases. At first most frequent in lungs and heart, they afterwards became more frequent in liver and lungs, the heart being relatively free. The ovaries were found frequently attacked in spring and summer, when functioning most actively, and seldom during the winter months.

The appearance of the cells microscopically varied considerably in different members of the same series. In some the original spindle shape was retained; in others the cells were mainly round, and the more slowly growing varieties were often characterised by the appearance of large numbers of giant cells, entirely different from those associated with avian tubercle and scattered indiscriminately among the cells.

Attempts to obtain growths of an unusual morphology by bringing the filtrate into contact with special types of cells have been unsuccessful, and the only variation found on injection of a filtrate attenuated in vitro was that the tumours took longer to appear and frequently retrogressed.

More recently, these observers have obtained specimens of growths occurring naturally in fowls which differ entirely from the above. Perhaps the most interesting is a tumour of low malignancy, first found in a Plymouth Rock hen. The original growth contained bone and cartilage, and was attached to the sternal keel of an otherwise healthy fowl. It was well encapsuled, on section hard and white, containing numbers of fibrous strands enclosing homogeneous translucent areas. Microscopically it presented the typical appearances of an osteochondrosarcoma. No secondary deposits were found in the original animal.

Portions of the tumour were grafted by means of Bashford's trocar into fowls of the same breed, some of other breeds, and into pigeons. This was attended with success in the first two cases only. In one instance only, in which a finely ground suspension of the growth in Ringer's solution was injected intravenously, were secondary deposits found. These, which occurred in the ovary and peritoneal cavity, resembled the primary tumour in containing prechondral tissue and cartilage, and were more cellular than the original.

It has also been found that the condition is transmissible, as in the case of Rous' spindle-celled sarcoma, by an agent separable from the tumour tissue by a Berkefeld filter. This, when brought into contact with connective tissue under suitable conditions, gives rise to the characteristic growth in which is laid down cartilage, followed often by bone.

These experiments seem to indicate that there are a number of conditions present in fowls which are indistinguishable by any means at present at our disposal from malignant growths in man, which are due to some virus capable of passing through a Berkefeld filter, and therefore presumably ultramicroscopic. All attempts to cultivate any organism have so far proved unsuccessful.

What other examples of so-called new growths can we find which can be traced to an infective origin? First of all, we have the wart or skin papilloma. Although the causal organism has not yet been discovered, there are very few who would be so brave as to state definitely that it does not exist. We do know that, in some cases, the so-called venereal warts, the condition is due to the presence of gonococci; in the idiopathic cases, in which this association does not exist, we must, I think, assume an infective origin owing to their well-known infectivity and contagious character.

Then, again, in molluscum contagosum we have the appearance of small nodules, often multiple, immediately beneath the epidermis. They consist of solid alveoli of epithelial cells arranged around a central point. The characteristic feature of the condition is the presence in some cells of the "molluscum bodies," originally regarded as protozoa and the cause of the disease. But since the condition has been shown to be due to an unknown organism of ultramicroscopic size—a filter passer—the molluscum bodies must now be regarded as structures formed by the cell in an attempt to wall the organism in and render it harmless.

In neither of the above conditions do we find any of the ordinary signs of inflammation, such as are sometimes put forward by opponents of the parasitic theory as distinguishing marks of lesions caused by parasites.

Another example of an infective lesion which reproduces perfectly the complex structure of papillary growths of the bladder and other regions is found in the rabbit's liver. It is due to the presence of the coccidium oviforme, a protozoon which is found embedded in the cells of the growth. The effect produced is similar to that of a papilliferous cystic adenoma, presenting none of the usual signs of inflammation except a fibrous capsule.

Turning to the connective tissues, we find the condition known as keloid. It consists of an overgrowth of fibrous tissue which may continue unchecked for many years, producing huge pedunculated masses. Its cause is unknown, but the following facts would indicate that it is of infective origin:—

1. It is commonest after accidental injuries, rare after surgical operations, and still rarer when the technique is strictly aseptic, and the wound heals by primary intention. A few cases occur idiopathically just as in other infections (erysipelas).

2. Although recurrence is common after excision has been performed, it is uncommon, I believe, to find people with keloid in one situation developing it in a distant wound healing by primary intention.

There is also the infective venereal sarcoma of dogs, described by Bashford, which is transmitted by coitus. This condition, in Bashford's own words, "is histologically identical with a round-celled sarcoma," and resembles malignant new growths in its local mode of origin, the invasion of surrounding tissues and organs, the apparent absence of immunity after successful inoculation, natural and experimental, and the limitation of transmission to one species. And yet Bashford, a strong opponent of the infective theory, maintains that this condition is not a true tumour because (1) it is infective, (2) it is transmitted by coitus, (3) the processes which occur in artificial transmission are identical with those by which tumour masses are formed as the result of inoculation with the tubercle or glanders bacillus. He concludes by assuming that the condition is a connective tissue reaction to a living virus not yet demonstrated; and yet he admits that it is similar in structure and behaviour to an ordinary sarcoma. Why, therefore, should not the latter condition be due to a similar cause.

Finally, there is the work of Fibiger, who found a type of flat-celled epithelioma of the stomach and œsophagus occurring in rats, embedded in the cells of which was a species of spiroptera which passes its larval stage in the cockroach. He produced these tumours in normal rats by feeding them on cockroaches infected with the larvæ. Metastases were found in distant organs.

In many other conditions has this association of parasites with malignant disease been shown. Lowenstein demonstrated the frequency of papilloma of the bladder in rats infected with trichodes; Haaland, of carcinoma of the liver in cows infected with distomiasis; Wassilewski, of gastric tumours of pigeons with dispharagus.

Immunity and Resistance.

Lastly, I should like to touch briefly on the question of resistance and immunity to tumours. Little is known about this subject in the case of man, but much light has been shed on it by the experimental study of tumours in animals. In the malignant growths of mice, for example, it has

been found that after transplantation through many generations the percentage of successes can be increased until practically every graft has a positive result. Even then, however, some mice still show themselves refractory to the tumour, indicating a natural immunity. Turning to the question of acquired immunity, it has been found that if a mouse recovers spontaneously from an early graft or even if the tumour is completely extirpated after growing for a time, it becomes immune and cannot be successfully inoculated with that tumour. It is even immune with respect to other tumours, and Ehrlich has termed this condition panimmunity. It can also be produced by inoculation of normal tissue or blood from another normal individual of the same species.

The almost universal immunity of animals of all species to transplantation of tumours of another species has long been the subject of much discussion, and is sometimes upheld as an argument against the parasitic theory. As such, however, it does not hold, because, in these experiments, it must be remembered, we are grafting the cells, even though they be abnormal ones, of a foreign species. The natural result of this will be, just as in the grafts of normal tissues, the production of what we term cytolysins, and other protective bodies, and consequent destruction of the alien cells. This would, of course, result in the liberation of the parasite, if such an organism exists, and it may well be asked, why does not this attack the cells of the host; the answer being that probably in many cases, as in the known infections, the particular organism is non-pathogenic to the species, and in those cases in which it is pathogenic the local conditions present are not suitable for its growth.

The experiments of Murphy in this connection are of considerable interest. He has succeeded in growing tumours of several different species, including man, in the young embryo chick, and found their growth in this situation as rapid, if not more so, as in the adult of the species from which the tumour was taken. These tumours persisted in their growth until the 18th day of incubation, when they began to be invaded by connective tissue fibrils of the chick, and within a very short time the whole mass had disappeared. What the cause of this remarkable change is, he has been unable to show, but from this time onward any attempt at transplantation of cells of a foreign species is always unsuccessful.

More recently he has shown that susceptibility to tumour implantation is very much increased both by exposure to X-rays and administration of benzol, both of which diminish considerably the number of lymphocytes in the body. He has also shown that previous grafting of lymphoid tissue or spleen diminishes the susceptibility to tumour transplantation; thus, by the addition of grafts of adult chicken spleen to the tumour grafts in the above experiments he was able to show that the latter very soon became surrounded by large numbers of lymphocytes and failed to grow. These experiments are of special interest in view of the fact that independent observers had shown previously that the cells which play the most important part in the reaction to the invasion of tumours, both in the animal kingdom and in man, are the "small round cells," or lymphocytes.

In conclusion, I should like to remark that, if the causation of tumours is to be attributed to parasites of various kinds, it does not follow that they should all be ultramicroscopic. Probably some of them are not, and the reason for our failure to find them is that the suitable stain has not yet been found. For many years the tubercle bacillus and the spirochæte pallida baffled us in all attempts to find them, but eventually were conquered by the improved methods of science, and I venture to prophecy that in the future the same will be said of the elusive parasites of tumours.

The habitat of these parasites, when producing these lesions, must be an intracellular one, and they must produce toxins capable of producing cell division. Although the evidence at our disposal is far from complete, it is, I think, sufficient to demonstrate that the hypothesis I am upholding is by no means a thing of the past and without foundation.

Papers by Guy's Men.

W. H. Jewell: Infiltration of Right Ventricular Band, Vocal Cord and Pyriform Sinus ?Malignant.—Proc. Roy. Soc. Med. xiii., April, 1920, Sec. of Laryngology, page 40.

W. M. Mollison, M.Ch.: Case of Fibroma of the Aryepiglottic Fold removed with the Aid of Suspension Laryngoscopy.—*Ibid,* page 19.

W. M. Mollison, M.Ch.: Case of ?Lupus of the Larynx.—*Ibid,* page 33.

W. M. Mollison, M.Ch.: Case of Melanotic Sarcoma of the Nose (Sections shown).—*Ibid,* page 39.

R. P. Rowlands, M.S., F.R.C.S.: A Clinical Lecture on Gall Stones.—*B.M.J.*, May 15th, 1920, page 665.

R. P. Rowlands, M.S., F.R.C.S.: Duodenal Ulcer, Gastrojejunostomy, Gastrojejuno-colic Fistula, Excision of Ulcer and Entero-anastomosis; Recovery.—Proc. Roy. Soc. Med., Clinical Section, xiii., page 59.

Alan H. Todd, M.S.: Case of Periosteal Sarcoma of the Clavicle; Clavicle completely removed Two Years ago; no Recurrence; Unimpaired Function.—Proc. Roy. Soc. Med., Clinical Section, xiii., page 67.

Philip Turner: Case of Sarcoma of the Scapula.—*Ibid,* page 49.

Reviews, etc.

Diabetic Dieting and Cookery. By P. J. Cammidge, M.D. (Messrs. Hodder and Stoughton, University of London Press); price 10s. 6d. net.

Dr. Cammidge gives in this book a practical account of the modern treatment of diabetes with a description of his own methods of testing for and estimating sugar in urine, and of estimating sugar in blood. Tables are included showing the amount of protein, fat and carbohydrate in convenient quantities, of a large number of food materials, and 189 suitable cookery recipes are given. The book is intended for the practitioner who is prepared to give a considerable amount of attention to the subject, but who is not an expert; and perhaps for this reason the caloric values of the foods are not given, in spite of their essential importance where a regulated diet is employed. The treatment recommended is essentially that of Allen with the modification that, before starvation is resorted to, a series of diets is given containing diminishing amounts of fat, protein and carbohydrate, of which the last one contains only vegetables and 2 oz. of milk. In this way an actual fast may frequently be avoided, a point of special importance when dealing with old people and children. In the same way, though a weekly fast is recommended during the progress of the case, this usually takes the form of a semi-fast, the diet consisting mainly of vegetables with perhaps a little meat or eggs, but no starch. Dr. Cammidge lays great stress on the importance of bringing the sugar in the blood to a normal figure before commencing feeding or making additions to the diet, but does not recommend actual starvation for more than three or four days for this purpose. When the diet has been established the patient should test his own urine for sugar and work out his diet from tables as far as possible, and the food tables given are designed with this end in view. The book is a thoroughly practical one, and should be of great value to those who are interested in the subject, but are not prepared to study the literature extensively. A few questionable statements may, however, be pointed out:—In the course of a short introduction the author refers to the influence of fat in increasing hyperglycæmia and glycosuria, but considers the explanation, that fat is transformed into sugar in the body, as untenable. When coma is threatening he recommends, as do others, a diet consisting only of a limited amount of oatmeal gruel, or well-cooked potato, in order to diminish the formation of acids, but for actual coma, although he quotes Joslin as advising that normal saline be used for intravenous injections and not bicarbonate, he himself favours intravenous injections of large doses of sodium bicarbonate or carbonate in spite of the fact that there is at present no evidence that the blood in diabetic coma is abnormally acid, and that therefore intravenous injections of alkali are liable to cause alkalosis. Finally, for purposes of diet, he compares children to adults according to their relative weights instead of the actual relation which is much closer to their relative surfaces.

Diabetes and its Dietetic Treatment. By B. D. Basu, Major I.M.S. (Retired). (The Panini Office, Bahadurjanj, Allahabad); price Re 1—8.

In this pamphlet the author propounds the view that diabetes mellitus is a result of alimentary toxæmia, the excess of sugar in the blood being the result of an attempt on the part of the body to neutralise absorbed toxins and not harmful in itself. Correct treatment, therefore, is to attempt to deal with the toxæmia, and only indirectly to diminish the hyperglycæmia and resulting glycosuria. He also holds that a liberal supply of "vitamines" will stimulate internal secretions and diminish toxæmia, and is, therefore, most desirable. The treatment he recommends is to give a diet, adequate but not excessive, consisting of vegetables, fruit, nuts, natural fats such as ghee and butter, milk, and suitable farinaceous materials, but no meat. Articles of diet specially recommended are: banana meal, which is made from unripe fruit and therefore contains little sugar, unpolished rice, which he considers superior to oatmeal in diminishing acidosis, and the cocoanut and preparations thereof as a source of natural fat, this in spite of the fact that the cocoanut is relatively poor in fat soluble A. Besides diet general procedures are recommended where there are indications for their use, such as attention to bowels and to teeth, gastric lavage, and the use of sulphur waters. He also refers to the cult of *Yoga* as being valuable for its cleansing properties. On this last subject one might wish to hear more, as to whether it has actually been tried and with what result, or whether at present it is merely a theoretical suggestion. Reference is made to acknowledged methods of treatment, notably that by starvation and underfeeding, and the author's views are supported by numerous references to scientific literature, but the work, though eminently suggestive, is confessedly unsatisfactory in that no evidence is brought forward to show that the author's methods are superior to those of others. It is especially difficult to judge, as the author states that in India there are no acute cases of diabetes, but that the cases approximate to the less progressive form—rarely terminating in coma—which in Europe is associated with the later years of life. The present pamphlet is the tenth edition of a work originally published ten years ago. The treatment outlined is similar in

many points to that in general use at present, though it differs in not aiming necessarily at diminishing glycosuria, and differs emphatically in theory. Even allowing for the fact that it has been largely re-written, the original edition must at the time of its appearance have formed a marked departure from current teaching and practice.

CORRECTION.

The price of Crowther's *Manual of Physics* is 16s. net. and *not* 12s. 6d.

Notices.

Examining Board in England by the Royal Colleges of Physicians of London and Surgeons of England.

On the 1st September, 1920, the following revised Scale of re-examination Fees will come into force:

For re-examination in:

		£	s.
First Examination	Chemistry and Physics	5	5
	Chemistry only	3	3
	Physics only	2	2
	Elementary Biology	3	3
Second Examination	Anatomy and Physiology ...	6	6
	Pharmacology & Materia Medica	3	3
Final Examination	Medicine	6	6
	Surgery	6	6
	Midwifery	4	4

FREDERIC G. HALLETT,
Secretary

29th April, 1920.

Royal College of Surgeons of England.

After the 1st June, 1920, the following Regulations relating to fees will come into force:—

DIPLOMA OF FELLOW.

SECTION II.

FEES.

1. The Fees for Examination are as follows:—

	First Admission.			Re-examination.		
	£	s.	d.	£	s.	d.
First Examination	8	8	0	5	5	0
Second do.	12	12	0	12	12	0

2. Of such Examination fees Twenty Guineas will be reckoned as the fee or part of the fee payable upon admission to the Fellowship.

3. The fee to be paid upon admission to the Fellowship is Thirty Guineas, except when the Candidate is a Member of the College, in which case the fee is Twenty Guineas.

The Newland-Pedley Gold Medal for Operative Dentistry.

CONDITIONS.

1. The Examination is open to all Students who have not studied in the Dental School of Guy's Hospital for a longer period than four years (in the case of those Students who have received tuition in Dental Prosthetics privately, two years), nor at any other Dental School prior to the commencement of their studies at Guy's Hospital.

2. Each candidate is required to give 14 days' notice of his intention to present himself for the examination.

3. The examination may extend over three weeks.

4. Each candidate shall:—

(i) Perform extractions under both general and local anæsthetics.

(ii) Prepare a cavity for and construct and insert a cast gold inlay. The patient is to be provided by the examiners.

(iii) Construct and apply an orthodontic arch with not less than two bands for posterior teeth and two for anterior teeth.

(iv) Write a thesis of not less than 1,500 words on a selected subject to be announced on the first day of the examination.

The Examination for 1920 will commence on Wednesday, June 23rd. Students intending to compete for the above should give written notice at the Medical School Office not later than Tuesday, June 8th, 1920.

The British Red Cross Society and the Order of St. John of Jerusalem have issued the following appeal to the public.

On the outbreak of war in 1914 there were two Corporations authorised to engage in relief work among the sick and wounded men of His Majesty's Forces, viz., the British Red Cross Society and the Order of St. John of Jerusalem. These two bodies worked independently, but quickly came to the conclusion that everything must be done to co-ordinate their activities and to avoid waste and overlapping, and that to this end it was expedient to "pool" their funds and their efforts. A Joint War Committee was formed, together with a Joint Finance Committee, and it is under these two Committees that the voluntary work of relieving the sufferings of the sick and wounded men of His Majesty's Forces has been carried out during the past six years.

During that period a vast number of workers, both men and women, throughout the whole Empire, gave unwearying and devoted service to the cause, and it was natural that, when peace came, there should be a general feeling that an organisation such as this, founded on the voluntary efforts of those

whose object was the relief of suffering and distress, should not be disbanded or allowed to disappear.

Moreover, there is still the aftermath of war to be dealt with. The Joint War Committee has been engaged since the armistice in carrying on certain of its War Departments which deal with work that must continue for some time yet to come, such as:—

The care of the sick and wounded men of His Majesty's Forces, whether still on the active list or demobilised.

Such care as may still be necessary for those who have been prisoners of war.

Assistance to Orthopædic Clinics and Curative Posts for the Treatment of Pensioners.

Home Service Ambulance Organisation.

Red Cross and St. John War and Peace Library.

There are also other branches of work which can usefully be undertaken in time of peace by the Order of St. John and the British Red Cross Society, such as:—

The care of those suffering from tuberculosis, having regard in the first place to sailors and soldiers, whether they have contracted the disease on active service or not.

Assistance, financial and otherwise, to the Voluntary Civil Hospitals, in view of the strain put upon these hospitals by the war.

Work Parties to provide the necessary garments, &c., for hospitals and health institutions.

Child Welfare work.

Assistance where required in all branches of nursing, health and welfare work, ancillary to the Ministry of Health.

The two Corporations were anxious that these various branches of work should be carried on, and felt that for this purpose a governing body should be set up in place of the Joint War Committee, which had been created only for work in time of war. They have, therefore, by a formal agreement, established a Joint Council, on which both bodies have equal representation. This Council possesses under the old Charter of the Order of St. John and the newly extended Charter of the British Red Cross Society, full power to act in all matters connected with "the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world." (Extract from Article XXV. of the Covenant of the League of Nations).

The Joint Council has now begun its work, and makes an earnest appeal to the public for a continuance of that great and munificent support which carried the Joint War Committee through the years of war. During those years the sick and wounded men of His Majesty's Forces learnt to look upon the Red Cross as an emblem, not only of help and comfort, but also of the devotion of the British people for the men who were fighting in Britain's cause. It is our earnest hope that those who, in peace time, are in suffering or distress, will learn in the same way to look to the White Cross of St. John and the Red Cross for comfort and relief, and will feel, when helped by the Order of St. John and the British Red Cross Society, that they are not receiving anything in the nature of charity but only the just and proper tribute from those who are enjoying health and strength to their fellow-men and women who are less fortunate than themselves.

For some branches of the work mentioned above—those in the first category—the Joint War Committee will continue to provide the necessary funds, either wholly or in part, for some time to come, but for all the other work of the Joint Council money is needed at once.

The greater the support that we receive from the public the better the work that we can do, and the more promptly we receive that support the sooner we can start our mission of healing and comfort. That is why we put forward this appeal, confident in the strength of our cause and in the generosity of the public that has never failed us yet.

Donations and subscriptions should be sent to:—

The Joint Council Finance Committee,
19, Berkeley Street,
London, W.1.

Cheques should be crossed "Lloyds Bank, Ltd."

ALEXANDRA,
President of the British Red Cross Society.

ARTHUR,
Grand Prior of the Order of St. John of Jerusalem in England.

May 15th, 1920.

Specialities.

VITAMOGEN.

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The preparation is largely soluble in cold water, the total soluble matters amounting to 62·80 per cent.

The Vitamogen Co. will be pleased to supply further particulars and to forward samples on application.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Report of the Medical Consultative Council of the Ministry of Health was published on the 28th of May, and it was not surprising that so important a statement was read with the greatest interest by millions of men and women in this country, to many of whom, the ideas it embodied were entirely new. Briefly, it is proposed to re-arrange our medical service and establish so-called primary health centres staffed by the local practitioners and possessing suitable wards, a dispensary, laboratory for simple investigations, massage, electrical and other departments. The staff of these centres would be able to transfer patients in need of hospital treatment from their houses to the wards of the primary centre, where, if required, the advice of consultants could be obtained and whence the patient could be transferred again to the secondary health centre for more specialised treatment.

In other words, the primary centres are to be linked up with the secondary health centres, established in large towns, embodying the various special departments, an ambulance, accommodation for work of communal service, and a personnel of part-time consultants and physicians and whole-time bacteriologists and pathologists.

Lastly, the centre of the whole organisation is to be the Medical School Hospital, where cases of unusual obscurity, necessitating highly specialised investigations could be dealt with. From these Schools, it is claimed, the "academic influence and spirit of inquiry associated with such hospitals," would radiate in all directions and exert its stimulating influence on the secondary, primary, and domiciliary services within their spheres of action.

In all of these institutions there is to be a standard rate of pay, for accommodation, food, nursing attendance, medicines and necessary investigations. While, in addition, the patient is to be responsible for the fees demanded by practitioners and specialists under whose care he has chosen to place himself.

The Consultative Council realises that the interests of the people will not be best served by establishing a full-time salaried state medical service. It has also made provisions by which all classes may receive, for suitable payment, the very best institutional treatment available.

Nevertheless, one must realise that there are no striking or revolutionary innovations recommended in the Report. After all, the pri-

mary health centres are only the Cottage Hospitals disguised by a new name, while in the secondary health centres we recognise the ordinary general hospital, slightly modified. In association with most of the existing hospitals there are, of course, special departments for dealing with ante-natal care work, child welfare, the early diagnosis of tubercle and treatment of venereal disease. In addition, similar welfare centres are maintained by Borough and District Councils, and every day these are becoming more numerous and more efficient.

We think that if only hospitals for paying middle class patients were built and the infirmaries were improved and developed, and if, in addition, arrangements were made by which the general practitioner was brought into closer touch with the general hospital, as at present constituted, a new scheme, with its primary, secondary, and tertiary health centres, would be unnecessary.

MEANWHILE, the general hospitals go on with their work, and the problem of how to increase their usefulness still more, is ever with us.

Anybody who has attended out-patients must have been struck by the enormous number of patients, with symptoms and no physical signs, who present themselves for treatment. Day after day, the unfortunates may be found, waiting patiently for their weekly dole of Mist. Acidi Co. They constitute the unwanted multitude, hampering the work of the special departments; they are the people in whom nobody is interested, and whom no one wishes to understand. These patients are not really neurasthenics, they are merely underfed and miserable specimens of humanity, in want of adequate stimulation, and until they get this stimulus they will go on attending out-patients week after week, year in year out, in the hope of ultimate cure.

We think that a special department should be established in every general hospital, in charge of a physician, interested in the complex clinical picture presented by people with "symptoms, but no physical signs." To this department the "chronics" would be transferred, by the physician or surgeon, who after examination could find in them no evidence of organic disease, and here they would be re-examined and treated by suggestion of the simplest kind, such as might be supplied by some crude vibratory or electrical machine or from any elaborate-looking devices which, as we know, are the delight of the laity and which prove so impressive to people of all classes.

In this way the special departments would be able to continue their work absolutely unhampered, while the "chronics" would receive in the *new* department treatment specially adapted to their individual variations and infinitely more efficacious than is the routine exhibition of a simple tonic mixture.

But most important of all, the physician-in-charge of this new department would accumulate material illustrating how often patients with symptoms and no signs, develope definite organic disease while under treatment. We know now, for instance, that of the people suffering from "soldier's heart" a year or two ago, many subsequently developed obvious pulmonary or cardiac lesions, and it seems possible that a careful study of those patients with so-called functional disorders would result in our obtaining valuable information about the symptomatology of disease in its very earliest stages.

ON the 3rd of June the Musical Society signalised the revival of its activities by an informal concert, held in the Nurses' Home. The programme was much appreciated, and,

considering the difficulties encountered by the Society during the period of rehearsals, the standard reached was excellent. Mr. Bradford —to whom the successful organisation of the concert was in no small measure due—is to be congratulated on the results of his efforts.

WE offer our congratulations to Messrs. W. H. Ogilvie, C. S. Lane Roberts, and J. Joffe, who have passed the final examination for the Fellowship of the Royal College of Surgeons.

IT is with the greatest satisfaction that we are able to record numerous successes on the part of the several athletic clubs connected with the Union.

The Annual Sports of the Athletic Club were successfully revived a fortnight ago; the entries for the events were numerous and the attendance was most satisfactory. In addition, the Club has become joint holders (with King's College) of the University of London Cup. A feature in the latter competition was the victory of a scratch tug-of-war team recruited on the ground from Guy's men present as spectators or competitors in the events.

Other noteworthy achievements, at both the Guy's and University of London Sports, were the excellent performances of C. L. Steyn in the 100 and 220 yards and of L. G. Housden in the long distance races.

By the victory of Guy's over St. Bartholomew's team on the 4th June, the Golf Club becomes holder of the London University Golf Cup for the current year.

Meanwhile, everybody is looking forward with the keenest interest to seeing Guy's in the Cricket Cup Final. So far the efforts of the Cricket Club have been attended with great success. Incidentally the performance of G. D. Shaw, who knocked up 120 runs against London Hospital the other day, merits special mention. It only requires the return to Guy's of the Inter-Hospital Cricket Cup (which we have not held since 1912) to make 1920 a record year in the annals of sport at this Hospital.

Appointments.

W. Bett, M.V.O., R.N., has been promoted to the rank of Surgeon-Admiral and appointed to Royal Naval Hospital, Haslar, Gosport.

C. Edwards has been placed on the Commission of the Peace for the Borough of Bridport (Dorset).

R. Sydney Harper, Capt., R.A.M.C., Approved Psycho-neurologist under Ministry of Pensions (Sussex Area).

H. Lee, F.R.C.S., appointed Lecturer in Ophthalmology to the University of Leeds.

Arthur William Ormond, F.R.C.S., appointed Lecturer in Ophthalmology, Guy's Hospital.

Change of Address.

W. Burridge, Capt., R.A.M.C., Hisleigh, Hyde Road, Paignton, Devon.

O. St. L. Campion, 85, Bromley Road, Shortlands, Kent.

E. P. Deverall, 118, Gloucester Place, Portman Square, W.1. (Phone Mayfair 4904).

H. G. Dresing, M.C., c/o Messrs. Holt & Co., 3, Whitehall Place, S.W.1.

W. E. Fox, 7, Homefield Road, Bromley.

R. Sydney Harper, Capt., R.A.M.C., 4, Adelaide Crescent, Hove, Sussex.

W. J. Henson, 21, Hanover Street, W.

W. Johnson, M.D., 26, Rodney Street, Liverpool.

H. Lee, F.R.C.S., 45, Park Square, Leeds.

E. P. Poulton, M.A., M.D., B.Ch., F.R.C.P., The Downs, Woldingham, Surrey, and 16, Cavendish Square, W.

Charles F. Sidley, Bagueley Sanatorium, Timperley, Cheshire.

Carcinoma of the Rectum.

CLINICAL LECTURE BY E. C. HUGHES, M.S., F.R.C.S.

GENTLEMEN,—

A few days ago in discussing carcinoma of the large intestine and rectum, I pointed out that the disease begins in the mucous membrane and at a very early stage becomes ulcerated, discharging into the bowel mucus, blood, and débris from its surface. As time passes, the disease extends in all directions, particularly around the bowel, but also in an upward and downward direction; it also extends through the coats of the bowel, and tends to invade surrounding structures, and, like carcinoma elsewhere, in time it spreads to the lymphatic glands and ultimately to the liver. As the growth spreads in a circular manner round the bowel, it tends to diminish the lumen; and in the majority of cases of carcinoma of the large intestine, it is the acute or chronic intestinal obstruction due to the diminution of the lumen, whether from the fibrosis accompanying the carcinoma, or from the polypoid masses of growth projecting into the lumen, or from some accident such as an intussusception of the growth that brings the patient to the surgeon.

The escape of mucus, blood, and débris into the bowel is more likely to be noticed by the patient when the disease is near the anus. I suppose most patients with rectal carcinoma present themselves partly because of the passage of bloody slime and partly because of the frequent stools containing very little fæcal material—the so-called "spurious" diarrhœa; in fact, there is a mixture of symptoms due to blockage of the rectum by growth and the ulceration of that growth.

In addition there will be constipation alternating with the diarrhœa, the latter essentially following the use of active purgatives, and lasting for perhaps two days.

Such symptoms are generally present with rectal carcinoma, and in too many cases have been noticed for many months, without exciting the suspicion of the patient, who imagines he has got "piles." Two male patients, whom I saw outside the hospital, would not believe that there was anything amiss other than constipation; one of them, who was suffering from chronic intestinal obstruction and large, fixed rectal growths, said he would be all right, if his wife gave him a large enema. I did not hear of that patient again for a week, when I heard that the enema had opened his bowels, but since that occasion in spite of repeated enemata, the action had not been repeated. I opened the abdomen intending to do a left inguinal colotomy, but before I could do this, I had to let out large quantities of fluid, containing turpentine, from the peritoneal cavity. I imagine that the enemata had been given with such vigour that in some way or another, the fluid had got into the peritoneal cavity.

The other patient had been suffering from increasing constipation for a year, and when I saw him had been five days without any action of the bowel, while previously to this he had been having many liquid motions a day. This man had an inoperable, fixed rectal carcinoma, with, I believe, secondary deposits in his liver. In spite of the symptoms I have told you, the patient had no idea that there was much amiss.

Another patient, an army nursing sister, had been treated for some time for dysentery, but a rectal examination revealed a carcinoma within two inches of the anus.

Two male patients who are in hospital at the present time, and from both of whom I have removed the rectum by the abdomino-perineal route, showed the following points: apparent duration of symptoms, twelve months; copper-coloured rectal discharge for two months, and frequent passage of blood and slime, but in both the motions were frequently normal in appearance. Both these men had carcinomata favourable for operation, *i.e.*, not attached to surrounding structures nor producing obstruction. Carcinoma of the rectum does cause

very definite sypmtoms, and it is difficult to know why the sufferers from it, and they are mostly men, delay in coming for advice. Many of them present themselves with the statement that they are suffering with piles. This "piles" story must not be accepted, until the piles have been seen and, in addition, the rectum has been examined with the finger and the sigmoidoscope.

Rectal carcinomata are situated either within reach of the finger, or at the level of the third sacral vertebra, which level, particularly in a fat subject, is out of reach of the finger, but a carcinoma at this level is at once seen with a short sigmoidoscope, the passage and use of which in rectal carcinomata does not require an anæsthetic.

Having decided that the patient is suffering from a rectal carcinoma, the question arises, "is it removable"? This cannot be decided in the affirmative until an exploratory laparotomy enables us to examine the growth from the peritoneal aspect, and to exclude enlargement (not necessarily involvement with growth) of the retroperitoneal aortic glands and secondary deposits in the liver. Such an exploratory laparotomy is the preliminary stage for the surgical treatment of the rectal carcinoma.

There are quite obvious indications that the growth is irremovable:—

1. Secondary deposits in liver, or malignant peritonitis, etc.

2. Fixity of the growth to surrounding structures; here judgment must be used; fixation anteriorly in the male precludes operation, but not in the female, for uterus and part of the vagina can be removed with the growth; fixity behind to the front of the sacrum, without fixity in front, can be disregarded, though it makes the operation risk higher.

3. The patient's general health; cardiac and renal disease, diabetes, etc., are very strong reasons for not entertaining the idea of a big operation such as removal of the rectum.

4. The too fat patient. Here all the operative procedures are going to be made more difficult owing to the bulk of the fat-laden structures, and unless the patient is otherwise healthy and free from disease, it will probably be wise not to operate for removal of the rectum.

I wish to point out again, that without a laparotomy it is impossible to decide whether a rectal carcinoma is operable.

What operation is to be performed? Very rarely cases are met with, where it is possible to resect a portion of the rectum, working via the anus, from the interior of the bowel. These growths must be of very recent origin, and limited to a very small area of the bowel wall. I have only met with one case of this kind. Such limited removals must be watched very carefully, lest recurrence should occur.

Excluding these very early cases, I believe that all others, in which the limit of the disease extends beyond the reach of the finger, should be treated by the removal of the rectum by the abdomino-perineal route.

In the removal of the rectum, the sphincters are considerably damaged, and the likelihood of efficient control over the fæcal contents is very small; a colotomy, therefore, becomes necessary in all cases. A colotomy is repugnant to most people, but will be preferred to a normally placed anus which is not under control. The removal of the growth from below is probably more difficult than by the combined method, particularly when the growth is at and above the level of the pouch of Douglas. Removal from below is a more "bloody" method than is the combined operation, where the superior hæmorrhoidal artery is dealt with in an early stage of the operation.

Some of you saw the combined operation performed on a patient in Job Ward. You will remember that he was fat, but except for this his general condition seemed sound. There was no great difficulty in the operation, though on opening the abdomen the bladder was found

to be distended with urine and appeared to have been so for some time. But in spite of this there were no great difficulties in doing the pelvic part of the operation from above, and there was not too much hæmorrhage during the perineal stage; and you will remember, too, the patient's excellent condition at the and of the operation.

At one time I dealt with these cases by a preliminary colotomy, doing the actual removal from below, but, in addition to the difficulty of this method, I have had, in two cases, recurrence in the end of the bowel, even when I had divided it at a considerable distance away from the cancerous growth. There are certain pathological findings, which indicate that the growth extends much more widely up the bowel than might be thought on superficial inspection. The great danger from the combined operation, apart from shock and hæmorrhage, is some septic complication, but if you carry out the operation as I suggest, I believe the septic danger can be largely avoided.

In the female, with her roomy pelvis, it is easy to exclude the perineal wound from the general peritoneal cavity by sewing the uterus and tubes to the peritoneum of the sacral promontory and lateral pelvic walls, but in the male there is much less available peritoneum, and unless this exclusion is done at the third stage, it is very likely to be an incomplete exclusion, and during the manipulation from the perineum, such sutures as have been inserted may tear out, making the exclusion between the general peritoneal cavity and the perineum still more incomplete. But if done as I suggest, it is quite easy in the male to completely exclude the septic perineal cavity. This cavity is lightly packed wtih gauze, with or without a large, soft-walled, rubber tube, and for the first week or so, is a septic cavity, with an offensive discharge. With attention it soon becomes converted into a comparatively clean cavity, which is slow in healing. The bladder must be carefully nursed, for, owing to the extensive dissection, its nerve supply is interfered with, and owing to the absence of the rectum it tends to sag backwards, and so there may be inability to pass urine, or only a portion of it may be passed, the rest remaining in the bladder, with the prospect of becoming infected.

The Operation.—Having decided that the growth as felt from below is mobile, and not too much attached to surrounding structures, particularly, in the male, to those in front, and that there is no apparent extension of the growth to the intra-abdominal glands, peritoneum or liver, an exploratory laparotomy is indicated to examine the growth from the interior of the abdomen, and to note its size, fixity, and possible extension to other parts.

The operation is done with less difficulty if an intrathecal anæsthetic is given, with or without inhalation anæsthesia, on account of the laxity of the abdominal wall, which it induces. The patient is elevated into a moderate Trendelenberg position and the abdomen opened by a large median incision. Having decided that the growth is removable, the pelvic colon is picked up and at a convenient spot divided, both ends being closed in one of the ordinary ways. The meso-colon is then divided down to the posterior abdominal wall, all hæmorrhage being prevented by preliminary tying of the mesentery in segments; at the base of the mesentery the large superior hæmorrhoidal artery will be found, and it is ligatured above and below and cut.

The next step is to divide the peritoneum on either side of the mesentery of the pelvic colon, down to the level of the third piece of the sacrum; this procedure is made easy by using the lower cut end of the colon as a tractor; the lower pelvic colon is now attached to the front of the sacrum by the fat of the mesentery, and it is easy by gauze dissection to strip the bowel and its fat free down to about the level of the third piece of the sacrum. In this fat there may be vessels which require ligaturing; if so, this is easily detected, as the fat will not separate easily by gauze dissection.

At this point the operator leaves the abdomen, temporarily covering it with a large towel and preventing the abdominal contents from escaping by packing with large pads.

The patient is then placed in the lithotomy position, or, as I prefer, in the left lateral position, with the left buttock on a firm pillow. A large steel sound is passed into the bladder and is held in position during the whole of this part of the operation.

An incision is then made encircling the anus and continued backwards and forwards, to the apex of the coccyx, and the centre of the perineum. The incisions are deepened through the ischio-rectal fossæ, picking up the inferior hæmorrhoidal vessels in the process.

The next step is to identify and cut the levatores ani. This is most easily done by dividing centrally just in front of the coccyx, and by passing a finger through this gap at the insertion of the muscles; the finger is then passed easily laterally and forwards on the upper side of the levator ani muscle, which is cut on either side by scissors, after placing artery forceps on the outer side of the incision; for on the upper side of the levator run the middle hæmorrhoidal vessels.

The anus and lower part of the rectum are now bare behind and laterally; behind, after getting above the levatores, the finger passes into a space from which the rectum is easily separated.

This is the coarse part of the perineal dissection, and attention must now be paid to the anterior attachments of the anus and rectum; the incision is deepened in front, until the steel sound is felt in the bulb of the urethra; above this, the rectum is carefully dissected from the urethra, which is seen in the wound; beyond this by careful knife and gauze dissection the rectum is separated from the prostate, and beyond this, by gauze dissection, until the vesiculæ seminales diverging above appear. The vesiculæ are the lateral boundaries of the bare area of the base of the bladder, and indicate that the peritoneum at the bottom of the pouch of Douglas has been reached. Carefully verifying that the structure supposed to be peritoneum is peritoneum indeed, and not bladder, it is cut, the sound being manipulated to indicate the position of the bladder.

The rectum is now free except for the peritoneal attachment on the side of the bowel; and the easiest way of proceeding is to pass the hand up the hollow of the sacrum and grasp the freed end of the pelvic colon and bring it to the exterior. Using this as a tractor, the remaining attachments of the rectum are easily identified and cut through.

After tying off the vessels, and removing the steel sound, the larger cavity resulting from the removal of the rectum is lightly packed with a gauze, preferably iodoform.

The operator now returns to the abdomen, having renewed his gloves, removes the large pads, and makes a small incision, through the abdominal wall, either muscle splitting or through the outer edge of the rectus. He then brings the free upper end of the pelvic colon through it and anchors the bowel by a few sutures. There remains the peritoneal toilet. On looking down into the pelvis, a large, funnel-shaped opening is seen at the bottom of the pelvis, due to the removal of the rectum. The peritoneum remaining in the pelvis is carefully brought together, even using the posterior bladder wall, if you are lucky enough to have a dilated bladder, such as I met with the otehr day. By careful sewing, the raw pelvic area can be entirely excluded, and I regard this as a most important step in the operation. The abdomen is now closed.

There is now appearing through the colotomy opening a closed piece of colon, and it is wise to introduce into it a soft rubber tube or catheter, through which fluid can be introduced into the bowel for three or four days.

The operation, as I have described it, is done in three stages: first, the abdominal freeing of the bowel from above; secondly, the perineal freeing from below; and thirdly, the abdominal toilet of the peritoneum (excluding the raw perineo-pelvic cavity from the general peritoneal cavity); and the completion of the colotomy.

The immediate dangers of the operation are shock and hæmorrhage, which can be largely prevented by spinal anæsthesia, careful handling of the peritoneum, the prevention of bleeding, and the subcutaneous infusion of saline, or the introduction of the latter into the upper end of the colon. I have already indicated that sepsis is prevented by excluding the inflamed perineo-pelvic wound from the general peritoneal cavity.

Another danger of the operation I first learnt after losing a female patient, who had not given any difficulty or anxiety for the first five or six days after operation, but who died in a few hours after the sudden onset of acute abdominal pain. At the post-mortem, the piece of colon which passed through the abdominal wall was found to have a gangrenous intra-abdominal part, continuous with a piece of gangrenous protruding bowel. This gangrenous part had suddenly given way and the bowel contents had escaped freely in the abdominal cavity. I realised then that in splitting the mesentery after dividing the pelvic colon, I had deprived the upper end of the colon of too much of its blood supply by dividing the mesentery too close to the bowel. So, when taking the colon through the abdominal wall, be sure that it has a proper blood supply; if there is uncertainty, bring out more colon, by mobilising the iliac colon if necessary.

It is not at all uncommon to get infection of the median abdominal wound, and it is as well to exclude it from the colotomy wound by a collodion dressing. On the third or fourth day, the colotomy will generally require to be opened.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Parasitic Hypothesis of Tumours.

DEAR SIR,—I have read with interest Mr. Ledlie's address to the Physical Society in the last two numbers of the GAZETTE. In relation thereto it may not be out of place to refer to the remarkable resemblance in histological appearances between epithelioma and the results of skin infection by the Leishmania tropica body—the so-called "Baghdad boil," which also has many other names. I saw many cases of the latter when consulting surgeon to War Hospitals in India. In certain suitable cases, *i.e.*, small and on an unexposed part of the body, they were excised (one I saw being excised as an epithelioma), and microscopical sections showed a structure indistinguishable from epithelioma. There are down growths of epithelial cells and cell nests. The condition is fully described with drawings of the microscopical appearances in a paper by my pathological colleague in India, Dr. William MacAdam, which appeared recently in the *British Journal of Surgery*, Vol. VII., No. 28, 1920, page 487.

Similar histological appearances have been noted in skin tubercle. It seems that the appearances result from chronic irritation. In two groups (Leishmania and tubercle), the source of the irritation is known. In the third (epithelioma), it would, I think, be worth while searching for a possible source by investigating the tissue juices from the edge of the sore, as is done in finding Leishmania tropica. It would also be interesting to see what the effects of the intravenous injection of sodium antimony tartrate on epithelioma would be. I saw in India the successful transference of the Leishmania tropica infection to the skin of monkeys by Dr. Row in his laboratory at the Grant Medical College, Bombay.

Cases of Baghdad boil are still turning up in this country. It has a long incubation period, and apparently cured cases may recur.—Yours faithfully,

A. W. SHEEN.

69, Wimpole Street, W.1.
May 31st, 1920.

SIR,—The experiments of Rous on the transmission of malignant tumours by means of cell-free extracts, referred to in Mr. Ledlie's address in your last number as evidence of a cancer virus, have

always seemed to me capable of another explanation, which is simpler in that it brings them into line with other data in the same field. It has been known for a long time that transplantable mouse carcinomata, occasionally change their character and become sarcomatous. The exact investigations of the Imperial Cancer Research fund showed that the connective tissue of the host, which is necessarily transplanted along with the malignant epithelial cells when a bit of the tumour is transferred to a fresh mouse, normally degenerates and disappears. Sometimes, however, and especially with slow growing carcinomata, it begins to grow a little in the new host, and this capacity for growth may be enhanced during subsequent transplantations. As a result a mixed carcinoma-sarcoma may be obtained, both connective tissue and epithelial elements being transplantable and tumourous. If, as sometimes has happened, the epithelial element fails to grow, a pure sarcoma is found. In other words, tumourous epithelial cells have so influenced normal connective tissue cells in their immediate vicinity that these latter have themselves taken on tumourous properties. A similar phenomena apparently occurs in the transplantation of sarcomata, but obviously the anatomical evidence in this case cannot be altogether convincing. The epithelial cell presumably influences the connective tissue cell by some substance passing from one to the other (spiritual influences cannot, of course, be altogether excluded, but it is convenient to ignore such possibilities as long as one has something else which can be put to experimental test). All attempts to demonstrate such a substance in extracts of ordinary mouse cancers have failed; the substance is apparently very labile and its existence is in some way bound up with the structural integrity of the cell. In Rous' chicken tumours it is, however, much more stable, and can survive extraction, filtration, and even desiccation; his extracts contain a tumour-producing *substance*, not a tumour-producing *organism*.—Yours faithfully,

A. E. BOYCOTT.

Radlett.
30th May, 1920.

The Site of the London University.

SIR,—The eleven and a-half acres offered for the site of the University of London is nearly the same as that refused for the purpose by the Senate and the London County Council in 1913. One of the chief reasons for its rejection was that the price of the land offered by the Duke of Bedford was considered by the London County Council Surveyor to be excessive. Another reason (speaking from memory) was that it was considered that Bloomsbury, though a genteel enough neighbourhood, was less suitable than South Kensington for the site of so important an institution; a riverside position on the Embankment and Somerset House itself were then suggested. So much for old history.

With regard to the present position, I understand from what I can gather that the London County Council and the University will again employ their expert in London site values to survey and estimate the value of the Bloomsbury property, and compare this estimate with the price the Government are prepared to pay for it. The Government proposal also includes the removal of King's College to the offered site, which would leave but little room for the administrative buildings of the University, and would lead to the duplicating of laboratories and class rooms, if centralised teaching be contemplated by the University in the new buildings. The site offered will entail the destruction of numerous dwelling houses and the closing of streets, and as the leases of some of these properties will not fall in for some years, the new structure will be patched with undesirable residences. As regards the financial aspect of the offer, knowing the present cost of building, are we justified in spending on "bricks and mortar" what will be required for educational purposes? Suppose the City and the generous public subscribe, as the Government suggest they should, possibly some three millions for the buildings, will it be fair to expect them to subscribe further for the endowment? At present the whole maintenance of the University is found by the Treasury, and the University is free of rates. With regard to this, the new offer of the Government *is, to say the least, ambiguous, and if the* University has to pay rates the matter would be extremely serious.

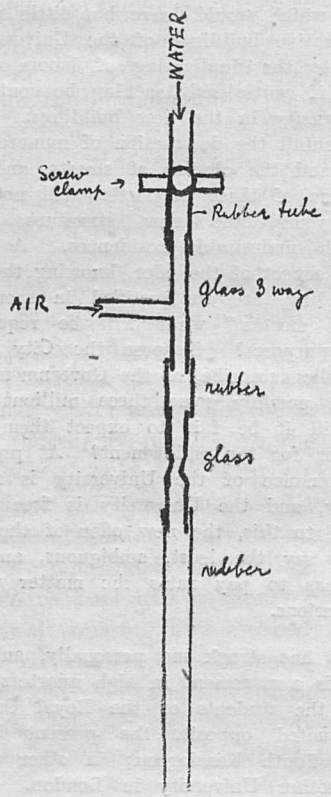
One point has struck me personally, and that is this: there is a movement in high quarters to grant degrees to the students of the Royal Colleges of Science, situated opposite the present University building at South Kensington; in other words, to establish another University in London. It would be highly advantageous to the promoters of this scheme to get the University removed from Kensington.

Some years back, the Senate applied to the Government to get these Colleges incorporated in the University, and the response was the Haldane Commission, which recommended the remodelling of the present University (including medical education) on German lines.—Yours faithfully,

A. PERCY ALLAN.

Croydon.
June 1st, 1920.

DEAR SIR,—The notes by Mr. Biddle in your issue of the 15th May on "Treatment of Peritonitis by Peritoneal Lavage" introduce the use of a water pump to assist drainage and keep the patient dry. It is curious that this method is not more employed where drainage has to take place through a tube against gravity. One can only suppose that the explanation is the inconvenience and wastefulness of a water pump. This can, however, be obviated by the use of a water Sprengel pump, which, if properly adjusted, can operate for a whole day with the use of only a gallon or two of water, and requires no fixtures.



The pump is made as follows:—A lotion jar with a tubulure at the bottom (or an ordinary jar or pail with a syphon tube) is placed on a table, and attached to the tubulure is the following series. Rubber tube with screw clamp, small glass three way tube, rubber join, small glass tube with central contriction, rubber tube running into a pail on the floor. The glass tube with constriction has to be made by trial, so that when the jar is filled with water and the flow of water adjusted to a slow stream by means of the clamp, the pump works, drawing air through the side tube. The side tube is attached through a reservoir to a tube inserted in the drainage tube as shown by Mr. Biddle. This tube must be appreciably smaller than the internal diameter of the drainage tube, so that it works by removing fluid from the interior of the drainage tube and does not exert suction on the interior of the cavity which is being drained.

A good plan to avoid kinking of the rubber suction tube is to have the bend made of glass, thus:—Rubber tube from reservoir, short glass tube bent at right angles, and then a short rubber tube of length adjusted to maintain the liquid in the drainage tube at whatever level may be desired, when the glass tube carrying short rubber tube is inserted into the drainage tube up to the bend.

This apparatus has been successfully used for suprapubic drainage, and would serve for intra-abdominal use with or without irrigation, provided the pus is not too viscid. The force of suction is dependent on the fall of water employed, measuring from the lateral air tube of the pump.—Yours faithfully,

J. H. RYFFEL.

Pass List.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, MAY, 1920.

Honours.

*G. B. Dowling.

*Distinguished in Medicine.

Pass.

T. G. D. Bonar.
G. O. Hume.
E. F. Kerby.
G. E. Kidman.
P. G. McEvedy.
W. W. Payne.
H. C. Rook.
P. D. Scott.
M. J. T. Wallis.

Supplementary Pass List.

The undermentioned passed in one of the two Groups:—

GROUP I.

J. V. C. Braithwaite.
J. G. Jones.
E. R. Webb.

GROUP II.

D. M. McManus.
R. W. Warrick.

SOCIETY OF APOTHECARIES OF LONDON.

Surgery.

*J. G. Barrie.
*C. C. Bennett.
W. H. Cellier.
*J. Kendall.
W. H. Summerskill.

*Denotes completion of Examination.

Medicine and Forensic Medicine.

L. Burvill Holmes.

Notes on Certain Types of Mastoid Osteitis.

BY A. M. ZAMORA, M.Ch., F.R.C.S.

II.—CASES POINTING INTO THE MEATUS And Illustrating the Importance of Careful Examination of the Meatus.

(1) D.H., æt. 31, attended Mr. Mollison's Out-Patients for right otorrhœa. History of attack of *pain in front and behind the right ear three months* ago, which disappeared in a few days. On examination the patient was looking pale and appeared toxic. The only objective signs were a very slight tenderness of the mastoid close to the attachment of the pinna, and the presence in the meatus of pus and a prominence of the posterior meatal wall, which was surmounted by some granulations.

It was decided to investigate this meatal swelling, and under gas the superficial granulations were removed, and probing revealed the fact that necrosed bone was underlying.

At operation Mr. Mollison found ulceration of the posterior meatal wall, pus and granulations were found in the mastoid, and the disease was so extensive that a radical operation was necessary.

(2) T.D., æt. 12, attended Mr. Mollison's Out-Patients for a pain in the ear. There was a swelling of the upper posterior angle of the meatus which was at first supposed to be a boil. A probe, however, passed into a bony cavity, and it was decided to open the mastoid.

At operation there was a large hole in the bony meatal wall, granulations and pus in the mastoid, and granulations on the lateral sinus and dura mater of the middle fossa just above the tegmen antri.

(3) J.B., æt. 57, was seen at Out-Patients on December 23rd, 1919, for earache. There was no pyrexia, and no swelling of the tissues over the mastoid. The only objective signs were tenderness and slight redness of the pinna and a slight swelling of the postero superior wall of the deep part of the meatus with an inflamed membrane. The case was regarded as a possible infection of the mastoid, and it was intended to watch her.

The patient, however, did not return to Hospital until March, when she had intense pain, deafness and vertigo. In the meatus she then presented granulations on the posterior wall, and it was obvious that there was a hole into the mastoid.

At operation the disease was found to have attacked the labyrinth, and an extensive operation was required, from which the patient recovered admirably, only to succumb later to pulmonary complications.

It will be seen that in each of these cases, which represent a definite type, the deciding factor in diagnosis was a careful examination of the meatal condition, and that if it had been possible to examine the meatus at an earlier stage, the patient might have been saved a great part of the necrosis.

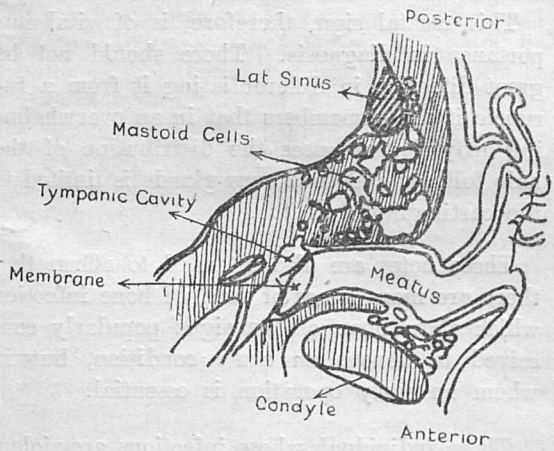


FIG. 1.

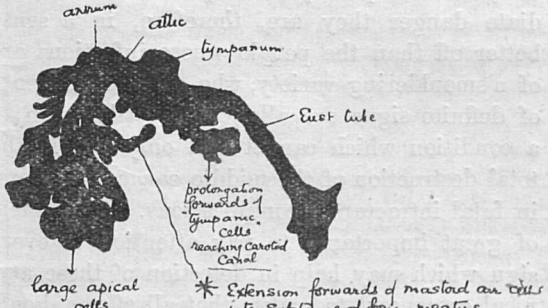


FIG. 2.

Metal Cast of Air Spaces of Middle Ear (Körner).

The accompanying figures from Cunningham and Korner at once make clear the very close relationship of the mastoid cells to the deep meatal region, yet when the question of mastoid infection arises attention is often concentrated on the presence or absence of swelling in the post-aural region and the deep postero-superior wall of the meatus whose relation to the infected part is just as intimate does not receive the attention it deserves. Actually in a large majority of cases of acute mastoiditis, the deep meatus is partially occluded by swelling of the posterior wall, and cases which actually perforate are not very uncommon, as is seen by these notes. Further, during operation it is often necessary to remove part of the meatal wall owing to the presence of infected cells.

This meatal sign, therefore, is of vital importance in diagnosis. There should not be great difficulty in differentiating it from a furuncle if one remembers that in an overwhelming majority of cases the distribution of the hair follicles and sebaceous glands is limited to the cartilaginous meatus.

These notes are also intended to affirm that there are many cases of mastoid bone infection which show none of the signs popularly conceived to denote an acute condition, but in whom an early operation is essential.

Those individuals whose infections are violent offer little difficulty in diagnosis, and are treated early and adequately. In spite of their immediate danger they are, therefore, in a sense better off than the people whose infections are of a smouldering variety, who, through absence of definite signs are allowed to settle down to a condition which can at best only end in the total destruction of the middle ear, and at worst in fatal intracranial complications. It is, then, of great importance to pay attention to every sign which may help in detection of these atypical cases, and to realise that all efforts should be directed towards the reduction to a minimum of the number of cases needing the radical operation, for it is abundantly clear that for a patient to reach the stage at which he needs a complete operation is something of a disaster denoting neglect or failure of treatment and offering him nothing beyond the eradication of disease by destruction of his precious hearing apparatus.

The value of efficient prophylaxis is more forcibly realised every day. Early and thorough treatment of oral sepsis, complete removal of tonsils and adenoids, adequate antiseptic measures and organised supervision of children have done much to reduce advanced aural disease.

There remain, however, a certain number of cases whose mastoids become the seat of disease and whose salvation lies in early diagnosis and immediate operative treatment. It is with the object of ensuring earlier diagnosis, that the importance of copious otorrhœa and meatal swellings has been emphasised in this series of notes.

My thanks are due to Mr. Mollison for permission to publish these cases.

Failure of an Amputation Stump to Heal, and its Probable Cause.

F.P. was admitted to Naaman Ward in April, 1920, under Mr. Rowlands. His history was that on May 2nd, 1918, as a consequence of a railway accident, he had an amputation of the right leg about "the site of election." Since then the wound has never properly healed, and the stump has always been painful, in spite of a second operation, at which the fibula was shortened, and of the injection of alcohol into the external popliteal nerve, which appeared to be responsible for the pain, in the popliteal fossa.

On re-admission in April, there was a raw surface of about two square inches on the lower end of the stump; X-ray examination showed some rarefaction of the lower end of the tibia stump.

On April 26th the limb was re-amputated above the femoral condyles. On dissection of the stump removed it was found that the lower end of the

musculo-cutaneous nerve was involved in the scar-tissue at the lower end of the fibula—thus, presumably, causing the pain, and probably also, by some trophic influence, accounting for the failure of the wound to close. It was also noted that the external popliteal nerve passed *between* the tibia and the fibula, instead of winding round the neck of the latter. Such an abnormality, of course, adds to the difficulty of locating and of dividing at a sufficiently high level the nerves concerned in an amputation.

Mr. Rowlands, who has kindly permitted me to make these notes, suggested ensuring the adequate shortening of the nerves of the stump by dividing them subcutaneously in the popliteal fossa, and removing the distal portions thus isolated.

M. H. M.

Guy's Hospital Nurses' League.

The Past and Present Nurses' League, which now numbers nearly sixteen hundred members, plays an important part in our Hospital life, and this is evidenced in many ways. A practical and sympathetic concern in all the affairs of the League has been shown by the Governors, members of the Medical and Surgical Staff, and their wives and daughters. The latter attend meetings and do all in their power to further the various activities that the present Hospital members enjoy. One of their number has always, most ably, filled the arduous office of hon. treasurer, Mrs. E. C. Hughes having now succeeded Mrs. H. C. Cameron in that capacity. Our sincere thanks are due to all these kindly helpers.

The Cottage at Honor Oak Park has invariably benefited by their interest, and we have now the pleasure of receiving from Lord Revelstoke and Mr. Cosmo Bonsor a generous gift to commemorate the work done by Guy's nurses at home and abroad during the war. This has taken the shape of adding and furnishing rooms at the Cottage, the provision of a new tennis court, and improving and beautifying the garden.

This will be a source of pride and delight to the Matron and Sisters and many generations of Guy's nurses. It is only necessary to attend an Annual Dinner to realise the hold that the League has upon past members. There can be witnessed the enthusiastic greetings of old friends and the exchange of experiences. If "it is the happy days which make us wise" these Guy's nurses owe much to their Hospital and gratefully acknowledge it.

From far and near over 200 past members assembled for the Dinner and Meeting on May 28th, and the function was a tremendous success. In the bright evening light the much loved plane trees were showing their freshest green. The Nurses' Home has never looked better, for two bands of Sussex school children had been pressed into service and contributed branches of birch and beech and tall buttercups to join the cornflower blue. The Home Sister must have felt amply repaid for all the thought and care she had given to the menu and all arrangements by the evident appreciation of everyone present.

The Matron opened the meeting, and after expressing the pleasure which she felt in welcoming those who throughout the long years of war she had so often pictured working, sometimes under distressing circumstances, in different parts of the world, Miss Hogg reminded those present that the past year had secured for nurses State Registration and the establishment of the first General Nursing Council. Guy's Hospital, too, had not stood still. Salaries had been increased and the working hours had been lessened. It was hoped shortly to secure for the staff, not an eight-hour day, with three shifts in the twenty-four hours, but a 56 hour working week.

The new building would allow of forty-one more bedrooms for the nurses, and a new shampoo-room has been built—(cheers)—a boon particularly needed now, when the charges at shops are so high. A small room where the nurses could do as they liked—wash and iron a blouse, sew, or make tea—is another improvement.

Miss Hogg asked Miss Constance Todd, R.R.C., M.M., who had been matron of the St. John Brigade Hospital at Etaples during the war, to take the chair.

The Matron, as Hon. Secretary, then presented a report of the year's work, and showed that the different societies and exhibitions are quickly reviving after war-time abeyance. The ninth edition of the *Nursing Guide* had been sent out to all members. Miss Hogg then enumerated the many honours which had been won by Guy's Nurses for War Service, and recorded with much regret the deaths of several members since the last meeting.

In the absence of the Hon. Treasurer, Miss Hogg also presented the financial statement, which showed that the amount of income over expenditure was £125 10s. 1d.; and with the balance brought forward from the previous year, £264 13s. 4d. The cost of printing the new Register was, however, so heavy—nearly £400—that the whole of this balance was swallowed up, and there would be a deficit at the end of the year if they were not careful. Part

of the cost would, however, be defrayed by advertisements; and members had been so good in responding to her appeal for a small donation that it was hoped they would have very little deficit to show. The cost of the upkeep of the Cottage would be very much increased, but the Governors had come to their help by giving a grant each year for the purpose.

Miss Todd then gave an interesting address, and spoke of her work at the Brigade Hospital at Etaples and the terrible time of bombardment. She also told a good tale of an old Scotch boxer who was brought in wounded. He so hated the Army and all to do with it that the Staff wondered why he joined up, as he was evidently over age. Then one day someone asked him. His reply was short but instructive: "A man needs to be a bit of a hero to stay at home in these days."

The meeting was brought to a close by votes of thanks to Mrs. Cameron and the retiring Hon. Members of Council. Miss Smith's work for the League is well known, and by a hearty round of applause the members endeavoured to show her their appreciation of it. Compiling the new Register was a great undertaking, while the success of the Photographic and Needlework Exhibitions are largely due to Miss Smith's initiative.

Farewells were lengthy, but the parting thought of all was—"to our next meeting."

Reviews, etc.

Gray's *Anatomy, Descriptive and Applied* (Messrs. Longmans, Green & Co.) 21st edition; price 42s.

"Gray" is the first book that the medical student buys with real interest. Anatomy to him means a subject with a clear bearing on his future work; later in life he realises that "Gray" is the last of his student books that he dares to lay aside. The present edition, from Professor Howden's prefatory note on the life of the original author, to the very last page well maintains the tradition of the premier English Anatomy. The modifications are restricted to the incorporation of recent work, such as Arthur Thomson's views on the rupture of the Graafian follicle, and of many new illustrations, among which the Hamilton Drummond arterial preparations are noteworthy for that simplicity which makes a strong appeal to eye and memory. We have always doubted whether the space available for microscopic anatomy in such a text-book is sufficient to enable even a fair summary of the subject to be given; in this edition many good histological illustrations appear for the first time, but, unfortunately, a few which remain would seem to have reverend age as their chief justification—surely, too, place should be made for a section of parathyroid tissue, at the cost, if necessary, of those of the carotid and coccygeal bodies. The surprising remark in the footnote on page 1154—"in fifty-two (out of one hundred subjects) their was neither an ascending nor a descending *colon*"—is doubtless attributable to the scapegoat printer.

M. H. M.

Medical Science—Abstracts and Reviews. (Published for the Medical Research Committee by Messrs. Humphrey Milford, Oxford University Press); price 2s. per month; subscription 21s. per annum.

We can unreservedly welcome this addition to current medical periodicals. The object of this journal is to present by means of reviews of the world literature the advances that are being made by workers in all countries. Hitherto such a periodical, corresponding to the German *Centralblatt*, has been lacking, and yet it is a matter of vital necessity to anyone who wishes to keep in touch with current work and thought. It is impossible to read all the literature, and unfortunately only too large a proportion of it is of very ephemeral worth. *Medical Science* endeavours—and we believe successfully—to fill this gap. The names of the editorial committee inspire confidence that each branch of the subject shall be dealt with by an expert who is well capable of judging the value of a new contribution to knowledge: Dr. J. D. Rolleston deals with Medicine, Mr. W. G. Spencer with Surgery, Professor W. Bulloch with Pathology and Bacteriology, Dr. Walshe with Neurology, Dr. Lazarus-Barlow and Professor Sidney Russ with Radiology, and finally Dr. Wolf is in charge of Biochemistry. Each number contains about half a dozen reviews, each devoted to some special subject, such as "Diseases of the Liver," "Latent Syphilis," "Surgical Treatment of Bronchiectasis and pulmonary abscess," to quote from a recent number, and amplified by a full quotation of the literature. Besides, there are abstracts, summarising special works. Each number contains about 100 well printed pages. With the carefully compiled index which is prepared for each volume, *Medical Science* forms, we believe, an indispensable work of reference. The latest—May number contains an interesting article on Spinal Anæsthesia, dealing more especially with the work of Jonnesco in Rumania, who has performed over 2,000 operations with spinal anæsthesia, many of these being in the region of the head and neck. He uses very small doses of stovaine, and has hitherto had no fatalities—very striking figures that ought

to increase the popularity of this method. Among other reviews is one dealing with influenza, especially as it affected Switzerland, and another with recent work on diseases of the blood.

Hints on Prescription Writing. By James Burnet, M.A., M.D., M.R.C.P.E. (Published by Wm. Bryce, Edinborough); 4th edition; price 2s. net.

This little book contains much useful information and will be helpful to those who are studying for examinations in pharmacy. Such questions as incompatibility and solubility of drugs are touched upon, and a useful list of doses and prescriptions appended.

The Radiography of the Chest: Vol. I., Pulmonary Tuberculosis. By Walker Overend. (Published by Wm. Heinemann); price 17s. 6d.

This, the first volume of Dr. Overend's book, deals exclusively with the X-ray diagnosis of tubercle. We think he shows thereby a very proper appreciation of the importance of his subject. The work commences with a detailed consideration of the normal chest and proceeds to consider the various manifestations of phthisis in its many early and late forms. In the various chapters the clinical history, physical signs, radiographic evidence, and often post-mortem findings are compared, and the parallels between the various examinations emphasised. We do not think that the author devotes sufficient attention to the radiographic differentiation of active and healed phthisis. Nevertheless, the illustrations are excellent, and we consider that the book is well worth the study of anyone interested in the radiography of the chest.

The Nursing of Chronic Patients. By Eleanor C. Barton, R.R.C. (Messrs. The Scientific Press, Ltd.); price 1s. 3d.

This little book should be most useful not only to trained nurses but also to the layman. It points out that in addition to actual skill, self-abnegation is essential in the nursing of chronic patients, who are naturally more troublesome and difficult to deal with than are the acutely ill people met with in the wards of an ordinary general hospital. The subject, skillfully and sympathetically treated, makes most interesting reading.

The Doctor's Manual. By Herbert Hart, M.S. (Messrs. John Bale, Sons & Danielsson, Ltd.) 4th edition; price 10s. 6d.

The author in his preface makes the optimistic claim that this book will enable the doctor to grapple with his ancient foe and prove the victor in every hardly contested fight. The first part of the book contains a pharmacopœia and useful directions for the making of stock mixtures and preparations. Perhaps the most generally useful chapter is that on the Spas and Mineral Waters. The Synopsis of Treatment includes within less than one hundred pages the treatment of every condition, beginning with Abscess and ending with Yellow Fever. Thus the treatment of puerperal septicæmia is dismissed in about twenty words. On page 202 the treatment of post partum hæmorrhage is given in nine lines. Line 7 recommends the exhibition of amyl nitrite, line 8 the administration of ergotin, ergotinne, morphia and strychnine, adrenalin and atropine sulphate, or pituitarin. In the article on antipyretics the only drug mentioned is the proprietary Genasprin. On page 77 there is a reference to the incision of felons; this, we take it, is a printer's error. We are told to avoid morphia in cases of neuralgia, no doubt because of the danger of a patient forming the drug habit. Nevertheless, for insomnia the author recommends his Mist. Sedativa 1 oz. p. r. n. This mixture containes one and a-half grains of morphine acelate to the ounce!!! On page 251 there is a list of Continental and other exchange rates on London, for the second day of February, 1920; it has historic interest. We realise that for the medical man, in general practice, descriptions of the value and applications of proprietary drugs may be very useful, but we think that the very numerous references to trade preparations, coupled with the inaccuracies scattered throughout the book, combine to make this work most unscientific, and, therefore, of rather doubtful value.

Athletic Sports.

Favoured with good weather and with an entry of over sixty, the Athletic Sports, held on Saturday, May 29th, at the Clubs' Union Ground, were very successful. Six hundred people, among whom were a large number of the Hospital Staff, witnessed the events, and letters were received from many others saying how sorry they were to be unable to be present.

The standard of running, taken all round, was good, the best performances being put up by C. L. Steyn, who won the "Clement-Lucas" Cup with 20 points.

The "Honor Oak Park Coronation Scurry Stakes" had an entry of 77, and many other jockeys were prevented from riding by the refusal of any of the donkeys to break into a trot. Next year it is hoped that mules will be available.

At the conclusion of the sports the prizes were presented by Mrs. Eason, whom everyone was delighted to see taking the chief part at the first post-war Hospital social function. With regard to the prizes, we should like to make it known that almost all of them were presented by members of the Staff. The names of the donors, except one, were unable to be printed in the programme, as the latter had to go to press so long before the Sports, and this opportunity is taken of acknowledging their generosity.

The results of the races were:—

100 YARDS SCRATCH.—1, C. L. Steyn; 2, C. V. Baugh; 3, J. Luke. Time, 10 3-5 secs.; won by 2 yards, 3 yards.

100 YARDS HANDICAP.—1, C. W. Greenway, 3 yards; 2, J. C. Rowbotham, 7 yards; 3, C. V. Baugh, scratch. Time, 10 4-5 secs.; won by a yard.

220 YARDS SCRATCH.—1, C. L. Steyn; 2, B. Cilliers; 3, L. P. Tupling. Time, 24 secs.; won by 8 yards, 2 yards.

220 YARDS HANDICAP.—1, H. Slater, 10 yards; 2, E. E. Neser, 8 yards; 3, C. V. Baugh, scratch. Time, 24 2-5 secs.; won by 2 yards, inches.

440 YARDS SCRATCH.—1, C. L. Steyn; 2, B. Cilliers; 3, C. W. Greenway. Time, 55 4-5 secs.; won by 5 yards, 2 yards.

440 YARDS HANDICAP.—1, C. W. Greenway, 5 yards; 2, A. S. Gough, 10 yards; 3, L. P. Tupling, 10 yards. Time, 55 4-5 secs.; won by a foot.

880 YARDS SCRATCH.—1, R. S. Chambers; 2, A. S. Gough; 3, J. A. Currie. Time 2 mins. 14 2-5 secs.; won by a foot.

880 YARDS HANDICAP.—1, A. S. Gough, 20 yards; 2, R. S. Chambers, scratch; 3, J. A. Currie, 20 yards. Time, 2 mins. 9 1-5 secs.; won by 3 yards, 5 yards.

ONE MILE SCRATCH.—1, L. G. Housden; 2, R. S. Chambers; 3, D. H. Oliver. Time, 4 mins. 55 2-5 secs.; won easily.

ONE MILE HANDICAP.—1, L. G. Housden, scratch; 2, G. B. Longhurst, 100 yards; 3, J. L. Faull, 100 yards. Time, 4 mins. 46 2-5 secs.; won easily.

THREE MILES SCRATCH.—1, L. G. Housden; 2, R. S. Chambers; 3, L. W. Houghton. Time, 15 mins. 57 secs.; won easily.

THREE MILES HANDICAP.—1, L. G. Housden, scratch; 2, R. S. Chambers, 45 secs.; 3, L. W. Houghton, 50 secs. Time, 15 mins. 57 secs.; won by 15 secs.

LONG JUMP.—1, C. L. Steyn, 19 ft. 3 ins.; 2, F. van der Hoven, 18 ft. 6½ ins.

HIGH JUMP.—1, R. R. Macintosh, 5 ft. 2¾ ins.; 2, J. D. P. Roberts, 5 ft. 1¾ ins.

PUTTING THE WEIGHT.—1, F. G. Hutchinson, 32 ft. 4 ins.; 2, F. R. Taylor, 29 ft. 10 ins.

THROWING THE HAMMER.—1, B. Cilliers, 66 ft. 1 in.; 2, F. G. Hutchinson, 61 ft. 5½ ins.

120 YARDS HURDLES SCRATCH.—1, J. Luke; 2, F. R. Taylor. Time, 18 1-5 secs.; won easily.

120 YARDS HURDLES HANDICAP.—1, J. Luke, owes 10 yards; 2, A. S. Gough, 5 yards. Time, 19 2-5 secs.; won easily.

MEDICALS v. DENTALS RELAY RACE.—1, Medicals. Won by 30 yards.

TUG OF WAR FINAL.—Second Year Medicals beat Dentals; two pulls to one.

HONOR OAK PARK CORONATION SCURRY STAKES.—1, H. G. Graham-Davies; 2, M. V. Ward.

"CLEMENT-LUCAS" CUP.—1, C. L. Steyn, 20 points; (runner up) R. S. Chambers, 11 points.

OFFICIALS.

Referee.—Dr. J. Fawcett.

Judges.—L. Bromley, Esq., C. H. Fagge, Esq., E. J. Holt, Esq., M. F. Hopson, Esq., H. C. Malleson, Esq., Dr. H. A. Munro, and F. J. Steward, Esq.

Starter.—G. D. Innes, Esq.

Timekeeper.—W. R. B. Thomas, Esq.

Inter-Hospital Athletic Sports.

The Inter-Hospital Athletic Sports will be held at Stamford Bridge on Thursday, June 17th, commencing at 2.15 p.m., and it is hoped that a large number of supporters will go down to cheer on our team. It is 17 years since we last held the Shield, but we have every reason to expect to regain it on Thursday. Suitable encouragement from the crowd may make all the difference to the result —and admission is FREE.

The team will be composed as follows:—

100 Yards.—C. L. Steyn and C. T. V. Baugh.

220 Yards.—C. L. Steyn and C. T. V. Baugh.

440 Yards.—C. L. Steyn and C. W. Greenway.

880 Yards.—R. S. Chambers and A. S. Gough.

One Mile.—L. G. Housden and R. S. Chambers.

Three Miles.—L. G. Housden and L. W. Houghton.

Long Jump.—C. L. Steyn and F. van der Hoven.

High Jump.—R. R. Macintosh and J. D. P. Roberts.

Hurdles.—J. Luke and F. R. Taylor.

Putting the Weight.—F. G. Hutchinson and R. R. Macintosh.

Throwing the Hammer.—B. Cilliers and J. Harvey.

University of London Sports.

The University of London Sports, held at the Herne Hill Track on Wednesday, May 26th, resolved themselves into a competition between Guy's and King's College for the "Rosebery" Points Cup, the final result being a tie with 39 points each. C. L. Steyn, by winning the 100 and 220 yards and getting second in the long jump contributed 18 points to our total, and J. Luke in the hurdles, L. G. Housden in the three miles, and the tug-of-war team contributed seven points each. Great praise is due to the last-named, who, being picked at the last minute and entirely untrained, carried out to the letter their instructions to "dig their heels in and pull like blazes," defeating a well-trained King's College team by two straight pulls. C. L. Steyn broke the 100 yards record for the Sports in 10 3-10 secs., and L. G. Housden the three miles record in 15 mins. 35 2-5 secs.

Golf.

Guy's and St. Bartholomew's played at Hanger Hill Golf Club on June 4th.

SINGLES.

A. C. M. Coxon (Capt.)	0	C. H. Bulcock	1	4 & 2
G. M. Stuart	1	C. H. Bracewell	0	5 & 3
C. Gill Cary	0	J. Ness Walker	1	1 up at the 19th hole.
K. F. McAlpin	1	C, Stuart Low	0	4 & 2
F. W. Stiven	1	F. C. Cozens	0	3 & 1
K. Hooper	0	S. Orchard	1	1 up.
	3		3	

FOURSOMES.

Coxon & Stuart	0	v. Bulcock & Bracewell	1	6 & 5
Gill Cary & McAlpin	1	v. Cozens & Low	0	9 & 7
Stiven & Hooper	1	v. Walker & Orchard	0	5 & 4
	2		1	

Guy's won by five matches to four.

Cricket.

GUY'S v. BECKENHAM.

Played at Beckenham on Saturday, May 15th, Guy's batted first, the feature of the innings being G. D. Shaw's 53. Had our fielding been better and the catches held (last year's complaint), the finish, I venture to think, might have been close. C. S. Hurst, the old Oxford captain, who totalled 55, was missed by Helder off a hard drive to mid off before he had scored, and Whitcombe's 26 was a cheery knock after the game had been won. J. Van Schalkwijk bowled well, and it is worthy of note that he secured the six wickets that fell.

Guy's.

G. D. Shaw, b Stenning	53
G. A. Milne, lbw Stenning	8
J. Van Schalkwijk, b Young	1
E. H. Muir Smith, b Young	3
T. Wooldridge, c Baker b Hurst	7
L. B. Helder, b Young	22
L. C. Willis, not out	21
T. J. Williams, st Whitcombe b Stenning	21
E. B. Corry, lbw Stenning	2
H. A. H. Harris, c Denner b Reed	0
H. Byron Davies, c Whitcombe b Reed	5
Extras	17
Total	161

Beckenham.

G. S. Johnston, b Schalkwijk	35
J. A. Speed, b Schalkwijk	11
C. S. Hurst, c Shaw b Schalkwijk	55
H. V. Coomber, b Schalkwijk	26
Rev. D. J. Scott, c Corry b Schalkwijk	30
L. H. Denner, b Schalkwijk	0
W. Whitcombe, not out	26
Extras	19
Total (for 6 wickets)	202

GUY'S v. SEVENOAKS.

A whole day match played at Sevenoaks on Whit Saturday. On a fiery wicket neither side's batting

showed to advantage, but G. D. Shaw did well—considering the procession to and from the Pavilion—to stay and make 42 out of 67. The scoring was so low, and the bowling good enough, that each side was able to bat twice.

Guy's.

G. D. Shaw, b Wells	42
G. A. Milne, st Heath b Battersea	6
T. J. Williams, c Seager b Battersea	0
L. B. Helder, lbw Battersea	5
J. Van Schalkwijk, b Wells	0
G. Shearar, b Battersea	5
J. C. Hewetson, b Wells	0
H. Slater, b Battersea	1
D. Eglington, c Denning b Wells	0
V. R. de Boissière, run out	5
F. R. Payne, not out	0
Extras	3
Total	67

Sevenoaks.

C. W. Denning, c Williams b Payne	2
W. H. G. Heath, b Schalkwijk	0
E. G. Seager, c Shaw b Schalkwijk	1
H. Thompson, c Helder b Hewetson	33
T. A. Grose, b Schalkwijk	21
H. Fuggle, b Hewetson	5
C. W. French, b Williams	6
H. Battersea, c Payne b Williams	0
E. Harber, b Payne	6
F. Smith, c Shaw b Schalkwijk	0
S. W. Wells, not out	0
Extras	5
Total	79

Guy's, Second Innings.

G. D. Shaw, c Grose b Wells	11
G. A. Milne, b Battersea	11
T. J. Williams, c Harber b Battersea	0
L. B. Helder, c Thompson b Battersea	0
J. Van Schalkwijk, b Wells	19
G. Shearer, not out	1
J. C. Hewetson, c Battersea b Wells	8
H. Slater, c French b Wells	3
D. Eglington, c Denning b Grose	5
V. R. de Boissière, c French b Battersea	1
F. R. Payne, st Heath b Battersea	4
Extras	5
Total	68

Sevenoaks, Second Innings.

C. W. Denning, st Eglington b Hewetson	21
W. H. G. Heath, c Milne b Schalkwijk	16
E. G. Seager, st Eglington b Schalkwijk	10
H. Thompson, c Shaw b Schalkwijk	7
T. A. Grose, lbw Hewetson	4
H. Fuggle, c Eglington b Schalkwijk	0
C. W. French, b Payne	28
H. Battersea, c Slater b Hewetson	2
E. Harber, st Eglington b Schalkwijk	15
F. Smith, c de Boissière b Hewetson	13
S. W. Wells, not out	2
Extras	16
Total	134

GUY'S v. HAMPSTEAD.

Played at Hampstead on Wednesday, May 26th. Guy's had the good fortune to bat first, as rain fell heavily after the innings was completed and stopped further play. Vincent Brown played a good innings for 57, his partnership with Helder for the second wicket yielding 83 runs. The eighth wicket partnership, Hewetson and Vaughan Roderic, yielded 50 runs.

Guy's.

C. V. Brown, c Gilman b Dumbleton	57
G. D. Shaw, b Hickson	1
L. C. Willis, b Burtt	1
L. B. Helder, c Gilman b Dumbleton	36
T. Wooldridge, b Dumbleton	0
J. Van Schalkwijk, c Hickson b Dumbleton	13
W. H. Willis, run out	10
T. J. Williams, c Dumbleton b Monroe	3
T. Vaughan Roderic (sub.), b Gilman	49
J. C. Hewetson, st Beaton b Gilman	22
F. R. Payne, not out	0
Extras	34
Total	226

GUY'S HOSPITAL v. LONDON HOSPITAL.

2nd Round, Inter-Hospital Cup.

Played at Honor Oak Park on Thursday, June 3rd. Guy's, winning the toss, batted first in a light that was none too good, and lost 4 wickets for 88. Shaw and Helder carried the score to 177, when the latter gave a catch to third man. L. C. Willis and Shearar ably helped Shaw, and the innings closed for 346. Shaw, who had a bad knee and employed a runner throughout, played a splendid innings for his 129, though his knee considerably handicapped him. London replied with 165. Burrell played a sound and useful innings for his side. Schalkwijk and Wooldridge both bowled well for Guy's—the latter's analysis being 5 for 40. W. H. Willis "kept" very well indeed. Scores;—

Guy's Hospital.

E. H. Muir Smith, c J. Swyer b B. Swyer	10
W. H. Willis, b B. Swyer	7
T. Wooldridge, b B. Swyer	20
J. Van Schalkwijk, b B. Swyer	28
G. D. Shaw, c Snaith b Rolston	129
L. B. Helder, c Swyer b McCarthy	49
L. C. Willis, c and b Rolston	30
G. L. Shearar, b B. Swyer	37
T. J. Williams, b B. Swyer	2
J. C. Hewetson, not out	2
P. B. Skeels, b B. Swyer	1
Extras	31
Total	346

Swyer, B. J., 7 for 121.

London Hospital.

J. Burrell, b Wooldridge	52
W. Castle, b Schalkwijk	4
H. Williams, c Shaw b Schalkwijk	30
A. Ainsley, b Skeels	0
B. J. Swyer, c Helder b Schalkwijk ...	3
E. Snaith, b Wooldridge	22
G. Sharp, b Wooldridge	15
G. Swyer, b Wooldridge	0
J. Adams, st W. H. Willis b Skeels	28
G. Rolston, st W. H. Willis b Wooldridge ...	0
A. McCarthy, not out	2
Extras	9
Total	165

GUY'S v. HONOR OAK.

Played at Honor Oak Park on Saturday, June 5th. Honor Oak batted first on a good wicket, and fared very badly, the score board showing 3 for 7 and later 5 for 29. E. B. Skeels bowled well, and had the excellent analysis of 6 for 44.

The Hospital, starting poorly, just failed to get the runs. Willis and Duncan played invaluable innings for their side, also Hewetson, who stayed at the wicket with Duncan at a critical period of the game.

Lockton bowled extremely well, and had the satisfaction of taking all the 10 wickets for an average of 5 runs a wicket—a fine performance.

The finish caused much excitement to a good number of spectators.

Scores:—

Honor Oak.

C. W. Lamb, b Skeels	1
R. Henty, b Schalkwijk	6
W. Gracy, c Duncan b Skeels	0
I. H. Lockton, b Schalkwijk	15
C. Wise, b Muir Smith	26
V. I. Cherry, b Skeels	4
L. Thompson, c Wooldridge b Skeels ...	26
G. Abel, b Skeels	4
O. Gorman, c Duncan b Skeels	4
—. Thorpe, c McKay b Skeels	10
H. Anson, not out	12
Extras	13
Total	121

Guy's.

E. H. Muir Smith, b Lockton	5
L. C. Willis, c Thompson b Lockton ...	31
T. Wooldridge, c Thompson b Lockton ...	0
L. B. Helder, b Lockton	13
G. L. Shearar, b Lockton	0
T. J. Williams, b Lockton	10
J. Van Schalkwijk, lbw b Lockton	0
R. F. H. Duncan, not out	28
J. C. Hewetson, b Lockton	12
A. L. McKay, b Lockton	10
P. B. Skeels, b Lockton	0
Extras	2
Total	111

GUY'S v. SOUTHGATE.

Played at Southgate on Wednesday, June 2nd. Southgate opened strongly, 170 being on the board for 3 wickets, H. A. Milton playing a fine innings for 80. Guy's suffered through lack of bowlers, but keenness in the field kept the runs down, and the last seven batsmen were dismissed for thirty runs. Guy's were left two hours to get 200 runs, which they just managed to do, but no more. The score stood at 192 for 8 when the last over was called and from the last ball of the match Harris was well run out in an effort to get the winning run. The batsmen took many risks in their efforts to obtain a decision, and the finish was most thrilling and full of keenness on both sides—result a draw, both totals the same, and Guy's a wicket in hand.

Scores:—

Southgate.

H. A. Milton, b Williams	80
M. A. Lewis, c Shearar b Payne	37
F. W. Barnes, b Williams	37
R. H. Rose, lbw b Hewetson	11
Rev. A. M. Bashford, c Willis b Williams ...	4
R. T. Barker, c Slater b Muir Smith ...	12
Hon. I. R. L. French, run out	1
A. E. Muddiman, c and b Hewetson ...	1
A. F. W. Thomas, ...	5
G. M. Phillips, not out	1
L. Geoffries, b Muir Smith	0
Extras	11
Total	200

Guy's.

E. H. Muir Smith, b Bashford	40
L. C. Willis, b Lewis	4
T. J. Williams, c Geoffries b Barnes ...	21
L. B. Helder, c Thomas b Rose	30
J. D. S. Thomas, c Thomas b Rose	20
J. C. Hewetson, b Lewis	13
G. L. Shearar, run out	29
H. Slater, b Rose	3
H. A. H. Harris, run out	9
F. R. Payne, not out	8
R. C. May, did not bat	
Extras	23
Total (for 9 wickets)	200

Guy's Hospital Rifle Club.

THE first shoot for the "Armitage" Cup took place on June 9th. Guy's were second. The scores were: Bart.'s, 414; Guy's, 394; London, 343; Thomas's, 309.

	200 yds.	500 yds.	Total.
G. W. Elkington	41	44	85
G. Beamish	39	37	76
G. V. Bingay	34	36	70
M. Wembrin	32	15	47
J. R. A. Moore	38	21	59
J. Meckleburg	34	23	57
	218	176	394

The next shoot will be on June 15th.

The Annual Prize Meeting will be on June 23rd and the United Hospitals' Rifle Club Meeting on June 30th.

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S., The Advantages Afforded by Extension in the Treatment of Diseased Joints.—*Lancet*, May, 1920, page 1159.

Lieut.-Colonel A. J. Hull, R.A.M.C., Direct Transfusion of Blood.—*Jour.* R.A.M.C., May, 1920, page 438.

E. G. Slesinger, O.B.E., M.S., F.R.C.S., Actinomycosis of the Cæcum, with Notes of an Unusual Case.—*Lancet*, June 5th, 1920, page 1220.

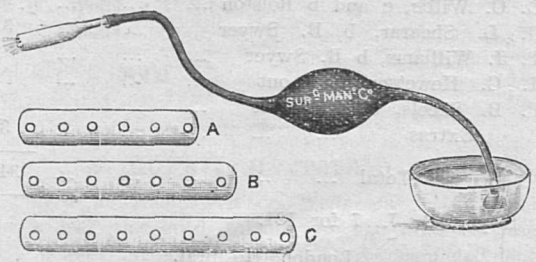
Honours.

C.B.E., MILITARY DIVISION.

Brevet Major Arthur William Ormond, F.R.C.S., R.A.M.C.(T).

Specialities.

The "BARTON" Combined Throat Irrigator and Tongue Depressor Nozzle. Produced by the Surgical Manufacturing Co., 85, Mortimer Street, W.1. The invention of a Guy's Nurse.



The nozzle is to fit on a Higginson syringe, and is in the shape of a hollow tongue depressor with a "rose" end, enabling the tongue to be depressed with the same instrument with which the throat is irrigated, thus doing away with the necessity for a multiplicity of appliances in the mouth, and allowing of a clear view of the affected part.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Births.

GARDNER-BROWNE.—On June 9th, at a Nursing Home, the wife of E. Gardner-Browne, L.D.S. Eng., of a son.

HOWE.—On May 21st, to Kathleen, wife of G. H. Howe, Elmcroft, Holden Avenue, Woodside Park, N., a son (Peter).

Marriages.

COXON-CLARKE.—On June 10th, at Lady Glenorchy's United Free Church, Edinburgh, by Dr. Harvey, Mr. Cedric A. M. Coxon, second son of Major S. A. Coxon, Kings Lynn, Norfolk, to Isabella Douglas, the only daughter of Sir John M. Clarke, Bart., and Lady Clarke, of 17, Rothesay Terrace, Edinburgh.

READ-HUTTON.—On the 2nd June, at St. Columba's (Church of Scotland), Pont Street, S.W., by the Rev. Archibald Fleming, D.D., Robert Sawle Read to Lizzie Blackburn, daughter of the late Mr. and Mrs. James Kilpatrick Hutton.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE representatives of the Rockfeller Foundation, believing that clinical teaching by the so-called Unit System is likely to be productive of the best results, have devoted a large sum of money to an experiment which, they hope, will prove the truth of their contention. Hence the recent gift of £1,205,000 to University College, which was such a source of surprise and satisfaction to the whole medical profession. In return for this capital outlay, the Foundation no doubt hopes to secure for the world perpetual interest in the form of improved research and corresponding advancement in the medical sciences.

Contrasted with this munificence is the sum of £1,000,000 which the British Government voted last year to *all* the Universities and Colleges in the United Kingdom, and also the blank refusal of the shareholders of a large and wealthy British Company to make over from their capital a grant of £100,000 in aid of scientific research.

University College Hospital, of course, has always played a prominent part in the fight against disease. But there are other institutions where the fight is being waged no less persistently and where, in other words, competent practitioners are being trained and scientific research is proceeding apace.

Surely a Government whose star-turn contemplates spending hundreds of thousands of pounds in replacing sombre post-war khaki by gaudy pre-war uniforms of the musical comedy type—surely such a Government can well afford to make grants, proportionate in magnitude, to those hospitals, where advances in the teaching and research departments are being hindered through lack of funds.

The generous gift of the Rockfeller Foundation is appreciated to the full, by English men and women all over the world, and we think the British Government would strengthen its position immensely if it followed the wise lead that has been set by a private American Institution.

AN interesting point that arises in connection with the Rockfeller gift is the stress laid by the Foundation on the adequate training of students in midwifery. We believe that at present midwifery teaching in the medical schools is very unsatisfactory. The London hospitals, unfortunately, are only able to devote a few of their beds to obstetric in-patients, and the student, having seen a few normal labours

in the wards, proceeds to his work on the "District," where all the abnormal cases that he meets are treated by the experts.

At all special manipulations — dilatation of the cervix, forceps applications and versions— he is a passive spectator, and the following paradox thus occurs: the very best students will, in time, obtain the appointment of House-Surgeon in the Obstetric Wards, or of Junior Charity, and will, therefore, have ample opportunity of learning how to perform most obstetric operations themselves. But the student of small or average ability will be compelled to face the world without having acquired this very essential knowledge.

It is only by hospitals devoting more of their beds to lying-in patients, or by the establishing of numerous maternity hospitals, that an opportunity will be found for every student to learn the more unusual and difficult manipulations that constantly arise in the course of obstetric practice.

WE announce on another page of the GAZETTE certain changes which the Editorial Staff of the Guy's Hospital Reports propose to introduce into its publication.

The object of these changes is to increase the scope of the Reports, to widen their sphere of usefulness, and, in fact, to adapt them in such a way that their value will be appreciated, not only by people actually connected with Guy's, but by everyone who wishes to keep abreast of current medical research.

Instead of appearing annually and containing only a few dissociated papers on special subjects, the new series of Reports will be published every three months, and, in addition to original essays on medical subjects, will present a résumé of all new work done in the hospital, and also reprints of papers by those old Guy's Physicians and Surgeons on whose pioneer work so much of modern medicine is based.

The present generation is all too unfamiliar with these historic theses, which demonstrate so well the achievements of clear-thinking and accurate scientific method. This is, no doubt, due to the fact that such original papers are very difficult to obtain and do not come the way of the average medical man.

We think that to the general reader the new series of Guy's Hospital Reports should prove of service, because it will be the epitome of all the new work that is being carried on at a centre of medical learning, while to present and past students of Guy's it should be of even greater interest, for it will constitute a continuous record of all that is being achieved at the hospital with which they are associated.

It is a human failing to deplore the passing of old orders and institutions and to look with disfavour, if not with distrust, on those innovations which, all unrecognised, are the essential links in the chain of progress. There may, perhaps, be a few people who will object to any alteration in the present form of the Guy's Hospital Reports, but the great majority of subscribers will look forward with the keenest anticipation to the appearance of the first number of the new series.

In the words of an old student, now in practice, "This new departure should be welcomed by every old Guy's man. It is just what is wanted, and for those isolated from the old hospital . . . it will form a stronger link."

It is hoped that all the old and many new subscribers will give the new series of the Reports their strongest support, for on this the success of the venture depends.

ON June 17th a team representing the Athletic Club was successful in winning the Inter-Hospital Sports Shield. We offer our congratulations to all those men whose enthusiasm and ability resulted in the return of the trophy to Guy's, after an absence of more than 20 years.

On the 30th of June the Cricket Club will be playing Middlesex Hospital in the semi-final of the Inter-Hospital Cup Tie. We hope that all those Guy's men who can possibly spare the time will turn up at our ground (Honor Oak Park) on that date, in order to give our side the support and encouragement it deserves.

Report of the Astley Cooper Student

For the Period Nov., 1919. to April, 1920.

THE duties of the appointment were commenced in November, 1919.

Throughout the tenure of the appointment attendances at post-mortem demonstrations were made whenever possible.

At these demonstrations specimens of the following were obtained:—

1. Aneurysm of profunda femoris artery, showing bony and cartilaginous changes.
2. Heart from the same case, showing infective endocarditis involving the aortic cusps.
3. Diverticulum of the aorta due to traction of pericardial adhesions.
4. Lung from a case of lymphatic leukæmia showing peculiar gelatinous œdema.
5. Heart from same case showing sub-epicardial petechiæ.
6. Liver showing secondary carcinomatous deposits (primary lesion in palate).
7. Bowel from same case showing ulcerative secondary deposit.
8. Early primary tubercular focus of lung from a girl aged 15 accidentally killed.
9. Liver showing infective cholangitis.
10. Granular kidney.
11. Granular kidneys.
12. Very large suppurative hydatid cyst of liver.
13. Jejunal ulcer following gastro-jejunostomy.
14. Suprarenal glands from a case of Addison's disease which showed no cutaneous or mucous pigmentation.
15. "Foaming Liver" due to post-mortem growth of gas-forming organisms.

All of these specimens were put through a colour-preserving process, as it was felt that one of the first needs of the Gordon Museum is a greater proportion of colour specimens, and, in fact, that, so far as possible, only colour specimens are worth adding to the collection. Descriptions of these specimens have been completed.

Specimens were also obtained by the courtesy of Mr. Laidlaw of:—

1. Amyloid disease of the suprarenal glands from a case showing Addisonian symptoms.
2. Kidney and suprarenal of an anencephalic monster showing diminutive size of latter gland in this condition.

Two visits were paid to Lambeth Infirmary, where by the courtesy of Dr. Perdrau, Pathologist to that Institution, specimens, among others, of the following were obtained:—

1. Cortical glio-sarcoma.
2. Ovarian cyst, with hæmorrhage into cyst cavity.
3. Pedunculated lipoma of small intestine.

A start was made to investigate the value of differential fat-staining in the gross.

In addition to the work mentioned above, the medical specimens at present in the collection were inspected with a view to marking those especially suitable for teaching purposes or for special study by students, as it was felt that the educational value of the Museum would be greatly enhanced if there existed a clearer differentiation between typical specimens of general interest and the more rare and uncommon specimens.

An unclassified assortment of kidney preparations in the Curator's Room was also examined, and descriptions of a number of these were written.

While realising that the last mentioned duties were not included in the terms of his standing-orders, the holder of the appointment felt that, where time and opportunity permitted, it was desirable that he should give help of this kind.

J. A. RYLE.

Change of Address.

E. P. Poulton, M.A., M.D., B.Ch., F.R.C.P., The Downs, Woldingham, Surrey, and 15, Cavendish Square, W. Telephones: Mayfair 1460; Woldingham 65.

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Lieut. N. King, R.A.M.C., British Station Hospital, Jubbulpore, Central India.

W. K. McKay, c/o Messrs. Grindlay & Co., 54, Parliament Street, S.W.

P. Scott, from The Mall, Wanstead, to 42, Devonshire Street, Portland Place, W.1.

Douglas Wain, O.B.E., L.D.S.(Eng.), Wentworth Villa, Alderley Road, Wilmslow, Cheshire (Phone Wilmslow 134).

S. S. Crosse, c/o Messrs. Grindlay & Co., Bombay, India.

A. P. Marsh, Dental Dept., Military Hospital, Devonport.

Hoarseness.

BY W. M. MOLLISON, M.Ch., F.R.C.S.

GENTLEMEN,—The subject of Hoarseness is a very large one and I do not propose to deal with it in detail, but rather to give an outline of its causes.

Clinically, hoarseness is a term which may include any variation of the voice from normal. It is used by patients indiscriminately for laryngeal hoarseness and for that brought about by extra-laryngeal causes; for example, any pharyngeal swelling such as a quinzy, which produces a thickness in the voice and growths in the pyriform fossa which may overhang the larynx.

Here we will deal with laryngeal hoarseness only.

The condition varies from a slight huskiness, barely perceptible to the listener (singers complain that their voices are hoarse where others would not realise that anything was amiss), to one in which the patient has the greatest difficulty in producing a sound at all and the sounds so produced are harsh and toneless; loss of voice, aphonia, is included under the term hoarseness.

In all cases the complete examination of the upper respiratory tract will be made and any abnormality in the nose, naso-pharynx or pharynx noted. Examination of the larynx must be directed to noting changes in (a) colour, (b) form, and (c) movement. These three headings are particularly useful when examination is being made in a difficult patient and when the observer is not an expert. The vocal cords are a pearly blue colour and meet at an acute angle anteriorly in the anterior commissure; posteriorly they are attached to the vocal processes of the arytenoid cartilages which articulate with the upper surface of the cricoid cartilage. Movements at this crico-arytenoid joint are two-fold: (1) inwards and outwards, thus approximating or separating the arytenoids; (2) rotatory on a vertical axis; this rotation allows of abduction or adduction of the vocal processes, and so of the vocal cords. The cords are abducted during inspiration, slightly adducted during expiration, and are brought close together during phonation.

Any departure from the normal anatomical appearances may explain hoarseness.

Roughly speaking, the clinical changes in the larynx in colour, form and movement correspond to three main pathological processes: (1) inflammations, (2) neoplasmata, (3) paralyses. It is obvious, however, that some pathological processes will lead to combinations of the three clinical conditions; for example, chronic inflammation may lead to changes in colour and changes in form — thickening of the mucous membrane at the posterior commissure; again, a change in form produced by a growth on a cord may lead to fixation of the cord; and lastly, paralysis of one vocal cord changes the normal form of the larynx. Bearing in mind that there is this overlapping, we will divide the causes of hoarseness into the three groups:

(1) Inflammations, acute and chronic, producing changes in colour of the mucous membrane of the larynx.

(2) Growths, innocent and malignant, producing changes in the form of the larynx.

(3) Paralyses, functional and organic, producing changes in movement of the larynx.

(a) Acute Inflammation results in general hyperæmia of the larynx, the cords instead of being pearly in colour become red, and the rest of the larynx, arytenoids, false cords, and epiglottis all become much redder than normal; this condition is acute laryngitis; it is as a rule due to an acute infection of the upper respiratory tract, in other words to a bad "cold in the head." It occurs in some of the specific fevers, notably measles. In connection with this subject remember that acute laryngitis in young children is often a very serious disease because it may lead to much swelling of the submucous tissue and to œdema of the glottis.

Diphtheria must be noted as a cause of acute laryngitis; in an infant the dyspnœa produced by diphtheria is indistinguishable from that due to acute catarrhal laryngitis (often associated with measles), and some of you must have seen in the post-mortem room cases in which tracheotomy has been performed, but in which there was no sign of membrane and no Klebs-Loeffler bacillus was to be found.

Other causes of laryngitis may be mentioned: extension of inflammation downwards from a severe tonsillitis, a quinzy, from an acute glossitis or from Ludwig's angina; both the latter conditions are very apt to cause œdema of the glottis.

Secondary syphilis produces an acute laryngitis, but in these cases there is always the typical symmetrical superficial ulceration of the tonsils and fauces and enlargement of the cervical glands.

Rarer causes of acute hoarseness are acute streptococcal ulcers on the arytenoids; two cases have recently come under my observation, in the first the ulcer was on the right arytenoid, about half a square centimetre in area, irregularly oval, with a grey floor and a red areola; clinically it gave rise to acute pain (not a usual symptom of acute laryngitis), worse on swallowing, a high temperature and some dyspnœa; antistreptococcal serum was given and recovery soon followed. The second case was in a lady of 64, the ulcer was smaller and on the left arytenoid; the chief symptom was pain especially on swallowing and in her case there was also a tonsillitis and stomatitis.

Some years ago I saw a doctor, aged 70, who had a very severe acute laryngitis localised to the arytenoid region combined with a pharyngeal swelling; he was extremely ill and had some dyspnœa; he had so much pain that he could not swallow, and a soft gastric tube had to be passed. His infection was due to the pneumobacillus of Friedlander.

Another condition that must be remembered as a cause of acute hoarseness and dyspnœa is angeio-neurotic œdema; if it occurs in a small child it is very difficult to diagnose, and a history of nettlerash or swellings in other parts of the body may help in coming to a diagnosis.

Occasionally it happens that children inadvertently swallow very hot or boiling water, as in drinking from a kettle; this leads to traumatic inflammation of the larynx and œdema.

Another cause of traumatic hoarseness is seen after external injuries to the larynx, *e.g.*, garotting, kicks received at football. Some years ago I saw a student who was kicked in the neck and became hoarse. Examination of the larynx showed a hæmorrhage into the left vocal cord; this cleared up in about 3 weeks.

Before considering chronic laryngitis, let us take a group of cases which are characterised by the recurrence of attacks of subacute laryngitis; these cases lead us to a consideration of the nose and nasopharynx. Normally air is inspired through the nose, and so is warmed, filtered and moistened; remember that the inspired air-stream passes up and back over the middle turbinals, the expired stream along the lower part of the nose; a very easy demonstration of this fact is given by examination of the nose of anynoe living in a dusty town; on the anterior end of the middle turbinal there is almost always a small collection of dry dirty mucus.

Should nasal obstruction occur, the air passes through the mouth, and is carried over the larynx unwarmed, unfiltered and dry, or at least drier than when it passes through the nose. The result is a constant tendency to irritation of the larynx, to mild infection from time to time, and so to the recurrent attacks of hoarseness. Patients with nasal obstruction are always worse at night and complain of a dry mouth in the morning; at a later stage in this condition hoarseness is noticed in the morning.

It is, therefore, important to examine the nose for deflections of the septum, for enlargement of the middle turbinals, for polypi or any other obstruction.

The nasopharynx must be examined for adenoids or other obstructions, *e.g.*, polypi growing backwards from the nose, or growth (rare), There is no doubt that the great majority of cases of recurrent and chronic hoarseness in children is due to the presence of adenoids; removal of the tonsils and adenoids cures most cases very quickly.

Now to pass on to (b) Chronic Inflammations: All the statements about nasal and nasopharyngeal obstructions hold good for chronic hoarseness as well as for recurrent attacks. We must add to the nasal conditions mentioned before deflected septum, enlarged turbinals, polypi—any sinus suppuration. In other words, in addition to obstructions in the nose all chronic infections must be considered; infection from sinus suppuration can pass down from the nasopharynx to the larynx and so cause chronic laryngitis.

Atrophic rhinitis leads to a special type of laryngitis; this is a disease in which the nose becomes much too roomy and the turbinate bones shrink. In consequence the air passing through the nose is not filtered and moistened; also crusts of dried mucus form; saprophytic organisms grow on the crusts and a characteristic and unpleasant smell is noticed. The whole respiratory tract becomes affected and as a consequence the pharynx becomes dry and crusts form on it and similarly in the subglottic space and trachea crusts form too. We cannot go further into the pathology and treatment here, but atrophic rhinitis must be noted as a well-known cause of hoarseness.

Two most important chronic inflammations of the larynx are tubercle and syphilis. Tubercle essentially leads to ulceration of the larynx; it is almost always secondary to tubercle in the lungs, and the presence of tuberculous laryngitis makes the prognosis of phthisis very much worse. The earliest changes are seen in the posterior commissure (as indeed are all chronic inflammatory changes) and consist in a heaping up of the mucous membrane. Later, swelling of the mucous and submucous layers in various parts of the larynx occur with shallow ulceration, later still ulceration may cause great destruction of all parts, epiglottis, cords and arytenoids. On examination of a case of tuberculous larynx the general impression gained is that of paleness as opposed to the redness of chronic catarrhal or syphilitic laryngitis. The diagnosis in an early case is very difficult, and rests on the finding of tubercle bacilli in the sputum. Every case of hoarseness of any standing must be looked upon with suspicion until examination of the sputum excludes tubercle.

Another form of tubercle that attacks the larynx is lupus; lupus occurs in the upper respiratory tract, in the nose, nasopharynx, soft palate and uvula and larynx; it gives rise to soft granulations combined with some ulceration.

Syphilis of the larynx occurs in different forms; often there is redness and great thickening of the mucous membrane and granulations projecting from the cords or arytenoids, partially obstructing the glottis; or there may be gummatous perichondritis, producing great swelling over the various laryngeal cartilages and resulting deformities, often with dyspnœa.

A rough rule may be formulated; tubercle of the larynx gives rise to hoarseness out of proportion to the changes observed and seldom causes dyspnœa; syphilitic laryngitis often leads to dyspnœa, but less hoarseness than the appearance would lead one to expect.

It is not unusual for syphilis and tubercle to be combined, and then the appearances and clinical course are often anomalous.

(To be continued.)

Honours.

O.B.E.

Douglas Wain, L.D.S.

A Case of Neuro-fibromatosis with Pituitary Symptoms.

BY A. W. ORMOND, M.S., F.R.C.S.

THERE has been a case in the Eye Wards during the last three weeks which is so rare and of such interest that I am going to examine it with you to-day at some length; it is as interesting from the neurological and dermatological point of view as from the ophthalmological, and the most careful records of it should be made as we have here a field for much fuller observation and research. I am indebted to Mr. Maizels for the clinical notes.

Ernest J., æt. 28, gardener, came to Guy's Hospital on the 26th April, 1920, complaining of headache and failure of sight.

V.R.E. 6/18 some; V.L.E. 6/18 some. Post-neuritic optic atrophy was present in both eyes, rather more marked in the right. Colour vision was defective; fields of vision were contracted. Wassermann reaction was negative. Hands and feet were larger than normal, and the supra-orbital ridges prominent. Kyphosis was present in slight degree.

The headache is referred to the right side and also to the occipital region. The history of the failing sight dates back vaguely to the time when the patient was in the Labour Corps in France, and he attributes it to the uncongenial task of acting as grave digger. He is mentally slow, being unable to read or write or to do more than the simplest arithmetic.

Over the covered parts of the trunk, both front and back, extending from the neck to the thighs, are extensive areas of pigmentation with freckle-like blotches and some areas of light brown extending to two or three inches in diameter. This pigmentation has been noticed since childhood, but some of the areas patient thinks have increased within his memory and become darker. In the skin and subcutaneous tissues are some soft, non-fluctuating masses which feel like fibrolipomata and are not painful to touch. These tumours vary in size from a pea to a mass an inch and a half across. There is one large one in his scalp, another over the left scapula, others of smaller size can be seen in various places, and on looking along the surface of the skin in a good light, a large number of undulations too small and smooth to be felt with the finger can be observed.

The heart is normal. Systolic B.P. 105; diastolic 80. Respiratory system is normal, except that the chest is irregularly shaped.

Patient is one of a family of twelve children, six boys and six girls. He has always been over-developed, and was in 1915 much bigger and stouter than at present; during the last two years he has been losing flesh. His appetite sometimes fails for days together, his mother says; and his sight varies considerably

Pigmentation and Multiple Neurofibromata in Von Recklinghausen's Disease.

FIG. I.

at different times. The stoop and general change was noticed in 1917 first of all, but the changes must have been very gradual, as the dates given by his mother are very vague.

His previous maladies seem to have been the usual exanthemata and three or four attacks of quinsy. There is a history of fits, one, which took place in 1919, nearly resulted in the death of the patient by being run over, and since he has been under observation he has had three attacks of headache with vomiting, but they are not of a very severe type.

We have, then, a group of symptoms similar in many respects to those described by Von Recklinghausen in 1882, and since by general consent associated with his name, viz., pigmentation of the skin in the unexposed parts of the body; the presence of numerous cutaneous and subcutaneous tumours in connection with the terminal filaments of the nerves together with a congenital mental deficiency; in addition there is a failure of sight due to the existence of an optic atrophy obviously the result of a previous papillo-œdema, and headache severe and prolonged. There are, too, sickness and occasional fits, an unusual enlargement of the hands and feet, and a prominence of the supra-orbital ridge and kyphosis. The X-ray picture (Fig. 2) is interesting in this connection; the sella turcica is certainly not enlarged, but the clinoid processes appear to be so and are apparently in close apposition, so that the sella turcica appears to be a triangular cavity closed above by the enlarged clinoid processes. There is a very interesting detail noticeable in the right fundus, namely, the presence of a small pale area above the optic disc under the superior retinal vessels which may, I think, be due to the presence of some hyperplastic fibrous tissue in connection with the optic nerve sheath, as it is continuous with the nerve head. On the other hand, the optic nerve symptoms may be due to a fibromatosis of the coverings of the chiasma, and this may account for those symptoms which seem to suggest some interference with the pituitary functions.

The case is a very interesting one, and all its points cannot at present be elucidated.

Von Recklinghausen's Disease is a name given to a condition in which there is a generalised over-growth of the connective tissue sheaths of the nerves. The peripheral nerves alone are usually affected, and molluscum fibrosum is essentially a fibromatosis of the terminal filaments of the cutaneous nerves and is frequently associated in the same individual with connective tissue over-growths of the trunks of the nerves. The nerve fibres themselves do not undergo any pathological change, at any rate in the early and slighter cases, but where pressure involves the nerve elements themselves, some degenerative changes may be

found. Microscopic examination of the cutaneous and subcutaneous tumours show that they are all of the nature of soft fibromata related to the terminal filaments of the cutaneous nerves, but there is neither new formation or any degeneration of the nerve fibres concerned. The consistency of the tumours may be firm and solid, or soft, and their vascularity small. Microscopically they may show small cysts or yellow pigmented areas of gelatinous softening. The number varies enormously, from half a dozen over the whole skin to many thousands. The condition has been found post-mortem, not having been suspected during life at all, so that the skin may be little or not at all affected; it is probably congenital in origin and progresses during life at varying rates, a marked increase in the condition being sometimes associated with puberty, while age probably has a diminishing effect in some cases. Neuro-fibromatosis may be looked upon as a condition of giantism or elephantiasis of the connective tissue elements of the peripheral nerve system.

Radiograph of the Base of the Skull, shewing marked rotation of the Clinoid Processes downwards into the Pituitary Fossa.

FIG. II.

PIGMENTATION.

Pigmentation is merely an excess of that which is normally present in the skin and is due to granules of pigment in the protoplasm of the cells of the rete Malpighii and in the connective tissue corpuscles of the corium and to a less extent in the intercellular tissue. There are two varieties of this: a punctiform variety very like freckles, on the covered parts of the body, not following any recognised nerve distribution or symmetry; and secondly, larger areas coloured café au lait similar to large pigmented moles.

Melanin is the substance which by its presence produces a true pigmentation of the skin, and consists of irregular granules of a brown or brownish black colour, soluble in ether, acids, alkalies and H_2O_2. It contains CHON and S. It originates (1) as an ultimate degenerative product of hæmoglobin; (2) it is a separation or secretion-product of the protoplasm of pigmented cells. Schmidt asserts that the coarse brown granules of hæmosiderin break up into fine blackish granules of melanin containing no iron and carried by chromatophores from the blood vessels to the epithelium. The chromatophores are leucocytes. After obtaining the melanin from the red blood cells the leucocytes carry it to the intra-epithelial lymph spaces. Hyperpigmentation also occurs in association with multiple fibromatosis. This has been explained by the French school as being caused by a lesion of the nerve supplying the the affected area.

May not the involvement in the disease of the supra-renal bodies have something to do with this process?

With regard to the remaining symptoms,

FAILURE OF SIGHT.

This is certainly due to a failure on the part of the optic nerve to conduct the visual im-

pressions received from the retina to the visual centres. The pupils are wide and sluggish in their reaction, the fields of vision are greatly and concentrically contracted. The colour vision is defective and ophthalmoscopically the optic discs show swelling and congestion. A vague history of fits and sickness and a definite complaint of prolonged and severe headache make a diagnosis of intracranial pressure highly probable.

The mental condition is interesting. The patient we are considering is a thoroughly good-tempered man, quite harmless and unworrying, but with a congenital incapacity to learn to read or write or count beyond (as he rather humorously remarked) the amount of his wages given to him every week. The external genitalia are normally developed, but he probably is an anaphrodisiac. His hands and feet are *undoubtedly larger than normal, his face is* heavy as well as his jaw. The general appearance of the whole frame suggests an acromegalic tendency.

I would suggest, then, that probably the condition of neurofibromatosis which exists in his general system is present in the cranial cavity and that the region of the pituitary body is largely involved, leading to a condition of "hypo"-pituitarism.

On the other hand it seems likely that at one time there was a condition of "hyper"-pituitarism (as the general enlargement of the limbs and trunk suggest too great a secretion), but that this was followed by a "hypo"-condition. Many points in the history and symptoms suggest an interference with the normal function of the pituitary body.

There are many interesting cases recorded of this condition of neuro-fibromatosis or congenital elephantiasis and some having a special ophthalmological interest have been described in the Transactions of the Ophthalmological Society. The eyelids are sometimes the site of this hyperplasia, and then we see a large, thick, pendulous condition which may be very *disfiguring and also may prevent vision* by rendering the eyelids immobile. Proptosis due to an increase in the orbital contents may produce a unilateral exophthalmos due to a plexiform state of the nerves, but one of the most interesting features associated with this disease is that of buphthalmia or a condition of congenital glaucoma. This has been investigated by Mr. Treacher Collins who finds considerable malformation about the filtration angle of the eye, as a result of an adhesion of the iris to the posterior surface of the cornea at its periphery, due to an imperfect separation of the iris and the cornea in fœtal life; but it is not quite clear what is the connection of this condition with the fibromatosis.

The ciliary nerves in the sclera have been found thickened by over-growth in the peri- and endoneurium. The iris, choroid and ciliary nerves behind the eye all show changes, but those that interest us most here are the changes in the optic nerve, because that is affected in our case.

The optic nerve is liable to become altered by a diffuse over-growth of its fibrous tissue elements. "Many neoplasms," Mr. Treacher Collins says in his report on one of these cases, "have been found not to be localised tumours, but a general diffuse hyperplasia of the fibrous tissue. This hyperplasia may involve the intra-cranial portion of the nerve as well as the orbital."

Microscopic examination of the cutaneous and subcutaneous tumours show that they are all of the nature of soft fibromata related to the terminal filaments of the cutaneous nerves. There is neither new formation of, nor any degeneration of the nerve fibres concerned.

With regard to the changes seen more particularly in the right eye, but present in both, are these pale soft areas continuous with the optic disc areas of fibro-plasia? Pale areas in the neighbourhood of the optic disc might be atrophic areas, or opaque nerve fibres; this they *certainly are not; they might be due to* organised exudation the result of the papillo-œdema. My own opinion is that they are areas of fibroplastic tissue similar to the fibro-plasia present in the rest of the body. Against this it has been pointed out that such a condition has not been recorded previously. I can only say that there must be a first case recorded, and it is, after all, one which fits into the picture most completely.

As you know the optic nerve is not really a peripheral nerve at all, but a prolongation of the brain; consequently it should not be involved in an affection which attacks the peripheral nerves only. Nevertheless, involvement of the optic nerve has been recorded, and Alexis Thompson in his monograph on this subject refers to four cases where the optic nerve was stated to have undergone changes. I think the

whole of the symptoms of this case may be explained by the hypothesis that the optic nerve, chiasma and sella turcica have been involved in changes similar to those which can be seen to exist in the skin.

Now this case emphasises very well the interdependence of all aspects of medicine and surgery. You have a medley of symptoms which, taken individually, seem to have very little relation one to another. The pigmentation, the tumour in the scalp, the large hands and feet, the failing sight, the headache and sickness, seem to have at first sight little to connect them together. It was a dictum of my old teacher, Dr. Pye-Smith, never to diagnose two diseases in one patient. "One patient, one disease," he used to insist, and this is a very sound conception. He did not mean to say that a patient could not be suffering from two separate and distinct maladies at the same time, but, generally speaking, it is more probable that one general pathological cause accounted for all the symptoms present in a patient at one time. I am quite aware that we have been unable to account for the existence of the pigmentation satisfactorily, but the association of molluscum fibrosum with pigmentation has been recorded frequently, and with certain reservations I think the whole of the symptoms present in this man may be explained by the presence of a fibrous hyperplasia in connection with the peripheral nerve fibres.

The forces regulating the growth of cells, their number and their size is obscure; why the cells constituting certain membranes develop to a particular size and then cease to grow, and why, when a certain number are laid down, no more are developed is not understood, but we do know that the pituitary body has some definite effect upon the development of size, though in the case under discussion we are not able to decide whether the pituitary body failed to limit the development of the fibrous tissue or the over-development of the fibrous tissue interfered with the normal action of the pituitary body.

With regard to treatment of the main pathological lesion, I fear we are rather in the position of the faculty recorded in the Cautionary Tales :—

"Physicians of the utmost fame
Were called at once : but when they came
They answered as they took their fees,
'There is no cure for this disease,'"

Relief to the symptoms, headache, vomiting and pain, on general principles is all that has been attempted, but Dr. Iredell is going to try the effects of X-rays and radium on the superficial tumours ,and then, should that prove satisfactory, he will go on and try what, I understand, has been attempted abroad, viz., the application of X-rays to the skull.

Guy's Hospital Reports.

With the issue of the Special War Volume of the Guy's Hospital Reports in the summer of this year, it is proposed to discontinue the publication of the Reports in their old form. In their place a quarterly journal, which will retain the old name, will be issued. It will contain an account of all new work done in the various departments of the Hospital, and as it will be issued regularly every three months the papers it contains will all be up-to-date and will not include reprints from other Journals.

Reviews of recent work in special subjects will be issued from time to time, and articles of historical interest, including reprints of classical papers by Bright, Addison, Hodgkin, Gull, and others from the earlier volumes of Reports, will be published.

The editor will have the co-operation of twenty sub-editors, each of whom will be responsible for collecting papers in connection with his special subject. It is hoped by this means to produce a journal which will combine the characteristics of the Quarterly Journal of Medicine, the British Journal of Surgery, the Journal of Laryngology, the Seale Hayne Neurological Studies, etc., under a single cover. The nearest approach to anything of the kind issued hitherto is the Johns Hopkins Bulletin, which enjoys a very wide popularity. Each number will contain about 128 pages and will be illustrated by an average of two whole-page plates, with a number of blocks in the text.

It is proposed that the annual subscription shall be two guineas, to include postage. It is hoped that all old subscribers will subscribe to them in their new form, and that many new subscribers will be obtained. As it is essential to have a sufficient number of guaranteed subscribers before the first number can be published, all who are willing to subscribe for one year are requested to send their names to the editor, Dr. A. F. Hurst, 17, Devonshire Street, W.1.

Stamboul.

I well remember the disillusionment of Constantinople. After months of waiting, of abortive sorties and false surprises, the talk of an early Turkish collapse, quickly followed by Turkish victories, the monotony under which the heart grows sick and the spirit quails, came the arrival of Turkish delegates to discuss the terms of armistice. It is an oft-told story, that conference brought about by a captured general, released on parole by his captors, but to us of the *Agamemnon*, living, as it were, in the heart of these momentous decisions, the dragging on of negotiations and *pourparleurs* seemed the straw that would bow down our impatient backs.

Turks, affable and charming, regaled the wardroom with stories of their love of Britain; our entry into the fallen capital would be a triumphant pathway of roses. The ship's encyclopædia (Vol. Con—Def) fell out of its binding at the end of a week. At length the delegates departed, and the ship, bereft of brass hats, relapsed into anti-climax. Constantinople became a visionary ideal, and everyone proceeded to resume whatever sport filled their leisure, Mudros being equally ill-adapted for any of them. Even that incurable optimist, the Commander, set off as his custom was on black days for a solitary expedition to shoot rock pigeon; and that is a sport one must have indulged in to appreciate. . .

And then, news! At dawn on November 12th the Allied fleets were to weigh anchor and proceed (blessed word!) to the Dardanelles, arriving at Constantinople at 8 a.m. the following day. Scenes of wild rejoicing, wherein £5 wine bills were as naught. The news of the Armistice which followed shortly after fell almost flat.

I ought, I suppose, to describe the progress of that strange Armada. How, in the pink of dawn, the ships set forth, spurning the waves, the rattling of chains in the hawse pipes, and all that sort of thing. But in our journeyings the start is seldom memorable, the doomed man on his last morning no doubt puts on his boots in no unusual way—and, furthermore, I was in bed at the time. Indeed, my first recollection is a sight of the low sand hills of Cape Helles glimmering in the noonday sun, the cloud-crowned mass of Samothraki astern, and on our beam the ruined fortress of Koum Kalessi and the plains of Troy. Stretching away till it seemed endless came the Allied fleet.

Ponderous Frenchmen, a medley of derricks, guns, and deck hamper; slender Italians, spotless in pale grey, with formidable triple mounted guns; Greeks, with their quaint lattice masts—the watching pack that had stayed the coming of the elusive Goëben. As we steamed past the historic beaches a hush seemed to fall over each little group of men; the *River Clyde* laying gaunt and haggard at the end of an improvised jetty, a French man-of-war, the *Massena*, hard by her, her light blue paint tinged with rust stains like the stains of blood, countless craft, some with their decks awash, some with scarce a masthead showing, whilst in dark contrast to the yellow brown of the cliff face loomed the scarred mass of Achi Baba—for a while the weight of memories seemed too great, and one gazed as upon the fallen curtain at the close of a noble tragedy.

Some identified here and there known scraps of earth, A beach, Y beach, Lancashire landing—to me it seemed as if every sod of that barren spit were in some way enobled and upraised. . . .

And so through Chanak to the Sea of Marmora, bleak and cheerless, and then at dawn—Constantinople. For all the sensation we created, we might, it seemed, have been a convoy of tramp vessels. Our time of arrival was 8 a.m., and shortly after, some distance outside what one gathered to be the city—for a heavy mist lay upon the water—ship after ship took up her station.

From the land not a sound reached us save the occasional screech of a locomotive at the great terminus of Haïdar Pasha; there was no sign of life from the invisible shore. As the morning passed the mist lifted slightly, and the keener eyed were able to see faint outlines in the direction of the port. At noon, as silently as we had arrived, we stole away. Not a shot had been fired nor a bugle blown; thus, as becomes our British way, did the Allies arrive at Constantinople.

Evening saw us in hiding in a deserted estuary, the Gulf of Ismid, where no one was allowed ashore on account of small pox—or was it typhoid?—and I think the only happy man on board was the Padre, who discovered that it was the scene of the contest St. George v. Dragon, and preached quite a breezy sermon the following Sunday in consequence.

As yet I have said nothing of Stamboul. Yet how should I? A fly cannot describe a pyramid, and who am I to describe what, as it seems, no mortal pen could compass? As I sit here in the silence, a chance picture seems to flit across my brain, rather, shall I say, a group of memories. Let me try to capture them for your pleasure.

It is September; that strange, lustrous month, contrast of radiant days and early storms when the prudent ones start to take leave of their villas upon the Bosphorus and to return again to the quiet streets of Stamboul. But to-day we have forgotten that but two days back the wind from the Black Sea chilled our bones, and like good Moslems are

seated in the sun, our *narghileh* bubbling pleasantly, the old *kafédjis* watching us benignly, for he knows well the two Franks who love to come and taste his coffee and think awhile, like any son of Allah. What he may think, I know not, for, alas! I have no Turkish, and of Greek he knows none. But he greets us graciously, and others seated at their little tables beneath the plane trees do not eye us altogether askance. And though I am, Heaven knows, no Turcophile (I have seen the handiwork of the Turk too often for that), yet one's heart warms a little towards these reverend greybeards. For they may be, have lost sons and brothers as we have, and loved and mourned them no less dearly, and now the struggle is past, sit and dream in the sunshine, while over the water in Pera Greeks and Armenians and Franks, the conquering *guiaours,* squabble and bicker for the spoils. Before us rise the grey outer walls of the Suleimanyeh Djami, that great mosque built by Suleiman the Magnificent, a dream in stone and burnished gold. Through the archway we glimpse the great courtyard, half deserted now in the heat, where surly camels lay in morose contemplation. At the *chesmeh,* a fountain of many basins, surmounted by a marble cupola, an old beggar is squatting, performing those ablutions required by the law of Islam. For a while one watches the remembered gestures: the cleansing of the ears, the mouth, the nostrils, the bathing of the feet and hands, that must precede worship within the mosque.

He is, perhaps, a *hodja,* a holy man, whose eyes have seen Mecca, and content with that supreme contemplation, has come home thus to die.

A horde of children, active as young sparrows, sweeps down the narrow street, dodge a lumbering ox-cart, and crowd around us, demanding alms. A few piastre notes, unwisely given, and the clamour rises to a tumult; for a moment the mild *Kafédjis* bestirs himself, and with a few vivid words the mob is dispersed. There is peace again till an old crone, brown and wrinkled as a chestnut, prods us insistently, murmuring a petition. . . .

My companion touches my arm, and after salutations we leave, to pick our way carefully down the cobbled street, avoiding pitfalls and heaps of garbage. For to-day we are upon a pilgrimage, a little journey of romance, and the wayside café beneath the plane trees marked but a stage of it. For we are to-day to search for the tomb of Aziyadé, beyond the walls at Yedi Koulé, and the café where we sat was the same at which a young naval officer, one Loti by name, had thirty, it may be forty, years before been wont to sit, waiting the hour when his mistress should come. Who was Aziyadé? What should I say, save that in pages half true, half false, a young man, after to be a famous writer, gives us the story of this little daughter of Islam, her pitiful child life, her welcome to peaceful death, in pages writ so skilfully that the pilgrim of to-day must needs follow for a while in those same footsteps.

Soon we leave the huddled shops and come out upon a vast scene of ruin and desolation. Passing hard by a ruined *tekkeh* or convent of dervishes we survey from a little height the scene before us. Almost as far as the waters of the Golden Horn lie piles of ruined masonry. Here and there a new house has been erected or a little cluster of buildings, a mosque perhaps, surrounded by plane trees, has withstood the desolation. Away behind us gleam the hundred minarets of the Turkish city, and to the right upon a hill, solitary and magnificent, the Selimyeh Djami, or Mosque of Selim II. But in the valley below us on either hand fire—it was the great blaze of 1888—has laid low fully a fifth of the city, as though some giant had crushed it with a mighty footprint. Here it was that the house of Aziyadé's master perished, and for a while we ponder on the heaps of rubble, half buried amid rank herbage. Passing on, we reach a village within the city walls. Old wooden houses, mysteriously silent behind their latticed balconies, lean over the narrow street. Dark moss-grown entries seem to invite the stranger, and within we see, around the sun-dappled courtyards, old infirm creatures, lodged in these *Hans* without payment, a bounty of some forgotten Sultan.

As we near the market place the road is almost blocked with the petty vendors with which Stamboul swarms. The boys with baskets piled high with nuts, chestnuts, hazel nuts, roasted peanuts, sunflower seeds, the old women with pale round cakes, decorated with a few grains of sesame or pistacchio, the sellers of *shiraz,* that half sweet half bitter beverage that the Moslem drinks, like the wines of Ismid, by the prophet's express sanction, the barrows with basins of *yourt,* the Bulgarian soured milk, that may, who knows, give long life to the faithful —seemingly every taste is studied. Here, too, is coffe, fresh boiled before your eyes, and here sizzling upon a little charcoal brazier succulent sausages, red and brightly speckled; hard by, upon a mighty spit a solid column of crackling mutton slices, the famous *Kevbab,* a little boy manipulates piles of savoury rice, wrapping up little bundles in fresh vine leaves —*dolmar* for the master's dinner. An ass, his packsaddle loaded high with gaudy bundles, jostles through the throng; his owner, far behind, encourages him with shouts and threats of punishment. There is noise, it is true, but not the clangour of the West, harsh and strident; rather, it seems, the play cries of a race young in its heart, with love and a kindly word for childhood or the aged.

G. H. F. G.

(To be continued)

An Account of an Epidemic of Typhus.

A short account of an epidemic of typhus in north Persia in 1918 may be of interest, not because of any original observations or pathological research, but because the epidemic though a small one, was very complete in itself, and I had the unusual opportunity of seeing each man from the day he reported sick, through his fever and convalescence. This was because we were a small British garrison at Kermanshah, a hundred and twenty miles from the nearest military post and practically cut off from all communications with them.

Famine was raging in Kermanshah. There were fifty deaths a day, and as many of these were from typhus, the town was put out of bounds a few days after our arrival. The troops, all British, were in good health after a long and arduous march and there was no sickness except occasional malarial relapses.

On April 28th one man reported sick with fever and two more on the two following days. On May 1st there were three fresh fever cases. The first man had developed a rash which resembled that of typhoid, but in view of the other suspects, all men with fever were isolated. On May 2nd and again on May 3rd there were three fresh cases, and the rash of the first case had changed considerably. The epidemic was definitely diagnosed as typhus. This diagnosis should certainly have been made sooner. The rash of typhus is really distinctive and the other differences from typhoid are considerable, even in the early stages, but previously I had only seen two cases of typhus in the isolation hospital at Baghdad.

In all, there were twenty-four cases, as shown in the following table :—

April 28th	1	May 5th	3
April 29th	1	May 6th	1
April 30th	1	May 7th	2
May 1st	3	May 8th	1
May 2nd	3	May 9th	1
May 3rd	3	May 10th	2
May 4th	2		

After May 10th there were no further military cases until the end of June.

As soon as the epidemic was diagnosed as typhus, a garden was taken over for the hospital and some old Russian tents were bought in the town. I had no medical orderlies, but four volunteers from the few remaining men worked extraordinarily well, and I received great help from the lady doctor at the American Mission.

Of the twenty-four cases, nine were severe, but before describing any of the complications it will be best to describe a case which was typical for this particular epidemic. The cases began in two ways. Two-thirds of the men reported sick with a shivering attack and high temperature (103°), which did not fall again till convalescence. One-third of the cases, including unfortunately the majority of the earlier ones had one or two days' low fever before reaching this stage.

The two prominent symptoms were intense headache unrelieved by aspirin and similar drugs, and great weakness coming on very rapidly. Some men complained of cough and pain in the chest and some of mild diarrhœa. Two or three rigors were common, but they were not nearly as violent as are the rigors of tertian malaria. Sweating was profuse and the skin was continuously moist. The tongue at first was clean and moist. By the fifth day the picture was greatly changed. The lips were dry and cracked. The tongue was dirty and the teeth covered with sordes. The patient lay quiet generally on his back. There was a fine tremor of the hands and of the lips. Even in the slighter cases the voice was mumbling and the tremor of the lips considerable. The rash generally appeared on the fifth day. For twelve hours it was not unlike the rose spots of typhoid. The next day, in addition, there was a general blotched background, looking something like measles. The mottled background faded on pressure, leaving hæmorrhagic spots. It was most marked on the abdomen and in the axilla, then on the inner side of the thighs and arms, and, finally, it covered practically the whole body. The rash generally faded after three or four days, but in acute cases traces remained as long as there was fever.

By the eighth day delirium was likely to develop, though in the worst cases it came on sooner than this. Three cases were entirely comatose with incontinence of urine and fæces from the seventh or eighth day, until their recovery.* Six other cases were delirious and

*One of these three died.

needed constant attention at night, as they were inclined to get out of bed and imagine that they were on guard duty, until they became too weak to move.

From the eighth to the twelfth day the temperature was lower than previously, but it fell by crisis between the tenth and fourteenth days, generally on the twelfth day.

Taking the various systems of the body in rather greater detail, one gets the following picture :—

Respiratory.—In most cases a cough was present during the first three or four days. This gave râles over the chest, but no other signs developed in any case. One case had a slight hæmoptysis.

Cardio vascular.—During the attack there were no signs other than those associated with any fever. Six of the more severe cases had a small thready pulse during the latter half of their illness. Two men developed femoral thrombosis during convalescence, about a week after their crisis. Practically all had severe tachycardia after the attack, but this will be referred to later.

Nervous System.—Extreme weakness was a very early symptom. In some cases a tremor of the lips and hands was noticed as early as the second day, and both were invariably present by the fifth day. The knee jerks were lost in all cases except one. Afterwards Colonel Willcox of St. Mary's, who was then consulting physician, drew my attention to the fact that this was a very early sign of great importance in diagnosis. All cases were dull and lethargic; nine had definite delirium, and in three of these the delirium passed into a condition of coma.

Alimentary.—There were no striking changes except the anorexia which followed on the dry parched mouth with sordes on the teeth and tongue, and in the three severe cases with incontinence of fæces. Four cases had diarrhœa, but in only one case was this at all troublesome. Two cases had rather persistent constipation. Abdominal pain was not a symptom.

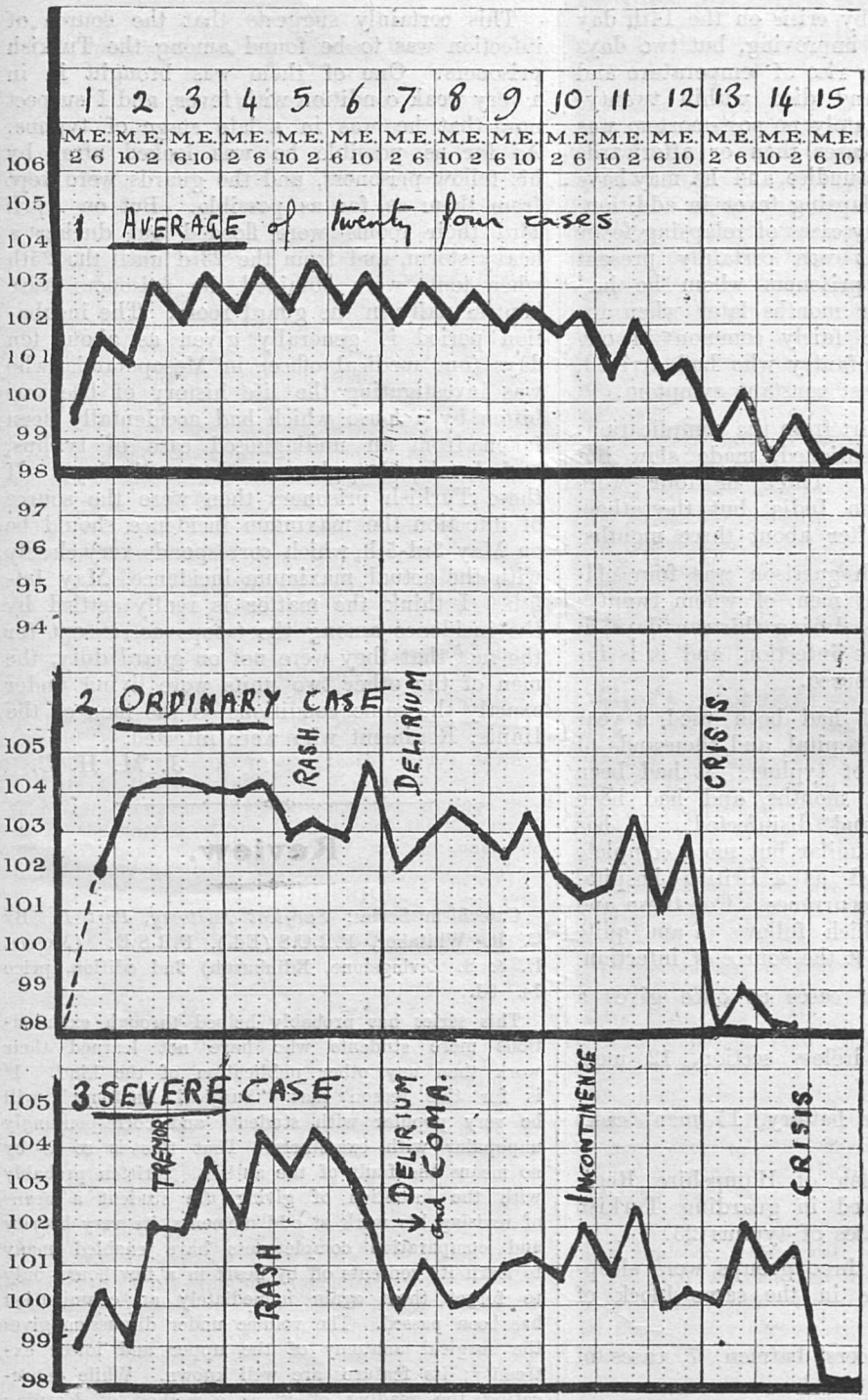
Urine.—The urine was not examined.

General.—The rash has already been described. In the Persian cases in the town who were starving and neglected, gangrene, especially of the feet, was common. In our cases the only similar troubles were bedsores in one of the severer cases and gangrene of the penis in one who was comatose for several days and who was suffering from gonorrhœa and a severe balanitis with soft sores.

As soon as the temperature fell there was a sudden change . The man slept quietly again and at once wanted light food. But he remained extremely weak, and only the one man already referred to was back at full duty within three months of the beginning of his illness. He returned to light duty after five weeks, and when I saw him two months later he was extremely fit and had marched two hundred miles during that time . He, like many of the others, lost his hair, and when I saw him had a head like a baby a few months old. With all the others tachycardia developed and delayed complete recovery. I do not think this was specifically due to the typhus, as all cases of fever, including ordinary malaria and the influenza cases five months later, were specially prone to develop tachycardia. It may have been due to the high altitude (5,000 feet) in men who were not then properly acclimatised.

Among the Persians convalescence was very rapid. Enormous numbers of the poor and badly nourished died. Osler gives the ordinary mortality as 15—20 per cent., but among the starving Persians it was certainly much higher than that, while among the troops who were well fed and well looked after it was very much less. But those who were better fed usually recovered and began to walk about again in the third or fourth week.

The treatment adopted was necessarily simple. On admission each man was given a bath and all his clothes taken away. With these precautions and treatment in tents in a previously unoccupied garden, none of the attendants developed typhus, although all the men were heavily infected with lice on admission. Eggs , milk, soup and bread were given as long as the patient would take them. This was generally till about the fifth day. After that only soup and milk were given. In the more severe cases alcohol (generally brandy) was given in large doses, especially towards early morning. Hypodermic injections of morphia were given freely to all cases in the early restless stages of delirium with definitely beneficial results. The mouth was cleaned as frequently as possible with glycerine. Water was given to the fullest extent possible.



This chart is drawn by averaging the temperature of all cases. This gives a regular effect but the sudden onset is masked by the cases with one or two days preliminary low fever, and the crisis is not well shewn as it varied from the 10th to 14th days.

This chart, of an ordinary case, shews the sudden onset—the steady temperature during the earl days—the somewhat lower temperature during the latter half, and the typical crisis on th 12th day.

This chart, of a severe case who recovered, shews the second less common mode of onset. (This was not specially associated with the more severe cases) — the sudden drop of temperature on the 6th day when the man became comatose and all the symptoms became worse, even he shewed a definite crisis on the 14th day.

Of the twenty-four cases only one died. He was a severe case from the beginning, and was comatose after the sixth day, and completely incontinent after the ninth day. His

temperature dropped by crisis on the 14th day and he seemed to be improving, but two days later he had a further rise of temperature and developed jaundice and died within twenty-four hours. Unfortunately no post-mortem was possible. No other cases then or afterwards showed any signs of jaundice, and he may have been infected with relapsing fever in addition. There were no military cases of relapsing fever at that time, but it was certainly present among the Turkish prisoners whom he had been guarding. Four months later when relapsing fever became fairly common in one regiment of Indian infantry who had arrived, jaundice was an almost constant symptom.

The other cases, apart from the complications which have been mentioned, made slow but uneventful recoveries. Three or four were ultimately invalided to India, but the others were back to duty after about three months.

As the total British garrison was four officers and seventy-eight men, of whom twenty-four developed typhus during thirteen days, it was obviously a severe infection, and it is interesting to trace its source.

The billet occupied had been used a year before as a Russian hospital, and thousands of men had died there of typhus. It had been unoccupied for seven months, and had been thoroughly cleaned and disinfected. It has since after a second similar but more complete disinfection been used as a British hospital without any further recurrence. For these and one other reason which follows I am quite satisfied that it was not the source of infection.

The distribution of cases at once gives a clue:—

1. New Zealand wireless section, 12 men, cases of typhus nil.

2. Armoured motor battery, 15 men, cases of typhus nil.

3. General duty men of Hampshire Regiment recently employed in guarding Turkish prisoners, 33 men, cases of typhus 23.

The men of these three groups were sleeping in similar rooms in the same block of buildings.

4. Officers and officers' batmen, 7, cases of typhus nil.

5. Men of Hampshire Regiment specially employed and not sleeping with the others, 15, cases of typhus 1.

This certainly suggests that the source of infection was to be found among the Turkish prisoners. One of them was brought in in a very weak condition with fever, and I suspect now that he was in a late stage of typhus. As far as possible he was looked after by his fellow prisoners, and the guards were kept from them as far as possible. But on April 23rd their rooms were flooded out during a heavy storm, and from the 23rd until the 25th when tents were obtained the prisoners were kept actually in the guard room. The incubation period is generally given as about ten days (one medical officer in Mesopotamia who was investigating the life history of lice was bitten by a louse which had accidentally been taken from an undiagnosed case of typhus, and developed typhus on the tenth day). If these Turkish prisoners then were the source of infection the maximum incidence should be on May 3rd-5th, which corresponds very closely with the actual maximum incidence, May 1st-5th. I think the matter is really settled by the incidence among the troops as, except for the fact that they were not on guard duty, the men of the other two units were living under exactly the same conditions as the men of the Hants. Regiment who were infected.

J. M. H. C.

Review.

Catechism Series: *Surgical Anatomy, Part I.* By C. R. Whitaker, F.R.C.S.(Ed.), F.R.S.E. (Messrs. E. & S. Livingstone, Edinburgh) 2nd edition, price 1s. 9d.

This series has probably helped through examinations more students who have not learned their work than any other publication of the kind. It is for this reason that "Surgical Anatomy" will be very popular with students and correspondingly unpopular with examiners. That this is so is by no means the fault of the author. Written probably with the intention of giving the student a means of revising his work at odd moments, its very brevity and comparative completeness have enabled many to learn its contents off by heart in a few hours, only to forget them again immediately an examination has been passed. The volume under discussion gives the surgical anatomy of the upper and lower extremity; its features are well known. While deprecating the reading of it as a method of learning surgical anatomy, we can recommend it as a means of revising knowledge primarily obtained from reading a larger book.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Wingent Memorial.

SIR,—We are writing to make known, through the medium of the GAZETTE, that the clock for the Will's Library, which was proposed as a Memorial to the late Ralph Wingent, has now been placed in position.

Owing to the outbreak of war in 1914 and to the complete disorganisation of the clock-making trade, it was not possible to obtain delivery of the clock which we ordered in July, 1914, so in December of that year we, who were both on active service, were forced to consider the possible abandonment of the original proposal.

It would have been easy to devote the sum collected to some other useful purpose, such as the purchase of books for the Library or the foundation of prizes for the Medical and Dental Schools, but as the war proceeded and several of Ralph Wingent's friends made the Great Sacrifice we felt more strongly than ever that the plan arranged with their approval should be carried through even if it meant postponement until after the war. The matter therefore has rested, and we have at length been able to obtain a Grandfather Clock of 18th Century workmanship with a handsome dial which will harmonise with the decorations of the Library and will be, we think, a fitting memorial of the artist whose friendship we so greatly valued during his years at the hospital.

The sum collected by us remained during the war in the charge of the Manager of the GAZETTE. and we append the statement of the accounts of the fund duly audited.—We are, Sir,

P. SEYMOUR PRICE,
51, Sloane Gardens, S.W.

H. CORRY MANN,
25, Harrington Gardens, S.W.

WINGENT MEMORIAL FUND.

Balance Sheet.

By subscriptions, as reported in the GAZETTE:—			
1. Sum held by the GAZETTE	£39	3	0
2. Interest for 5 years at 4 per cent.	7	12	6
3. Cash in hand	2	14	6
	£49	10	0
To Messrs. Gill and Reigate, Oxford Street, an Oak Tall Clock with brass dial by J. Stokes, Bewdley	£46	5	0
Balance to Wills Library Committee for necessary upkeep	3	5	0
	£49	10	0

Audited and found correct,
W. J. CURRY.
22nd June, 1920.

A Case of Otitis Media caused by Scalds.

A.M., a woman aged 26 years, attended out-patients for aural discharge. She gave the following history. Three months previously some boiling tea had been spilt over her, causing burns of the second degree on her right shoulder, neck and right side of face. She was under treatment in an infirmary for these for a period of two months.

She had never had any trouble with her right ear previously, but directly after the accident there was a discharge of blood, which was soon followed by a flow of pus; the latter has since continued.

On examination a small antero-inferior perforation could be seen with a red area around. On raising the pressure in the middle ear pus could be easily seen bubbling through this perforation.

There can be no doubt that the perforation and otitis media were directly due to scalds of the tympanic membrane.

I am indebted to Mr. Mollison for permission to publish this very interesting case.

W. K. M.

Guy's Hospital Musical Society.

A most successful concert was given by the Guy's Hospital Musical Society in the Nurses' Home on June 3rd, under the able conductorship of St. John Bradford, Esq., organist and musical director to the Hospital, before an audience which included Mr. and Mrs. Eason, Mrs. Ryle, and the Matron of the Hospital. The Rev. A. J. Hawkins (Chaplain) acted as M.C.

The programme, noteworthy for the predominance of modern British works, was rendered in most excellent style (especially the choral numbers), the conductor opening both parts with some masterly pianoforte playing.

Of the part-songs, perhaps Walford Davies' "Lullaby" and Hubert Parry's "Jerusalem" were the most effective. The former was in lighter vein, the latter, typical of the late master's work, was especially well rendered.

Of the individual items, Nurse Johnson's violin solos, together with vocal solos by Nurses Young, Dalbiac and Groom, and songs by Mr. Gallagher were received with "roars of applause" and insistent demands for encores, which were willingly given.

During the interval, the Rev. A. J. Hawkins spoke briefly and appropriately on the progress made by the Society, which has been lately revived after several years' quiescence, and appealed for in-

creased support by those endowed with musical talent. After the proposal of a vote of thanks to those whose efforts resulted in the success of the evening, refreshments were kindly supplied by the nursing staff.

Unfortunately, one marked feature of the audience was the almost complete absence of members of the Medical and Dental Schools—between them they could only muster seven men. It seems that this was entirely due to the lack of advertisement and consequent general ignorance of the fact that any concert was contemplated.

Inter-Hospital Athletic Sports.

Our most sanguine hopes were realised at the Inter-Hospital Sports on Thursday, June 17th, when not only did we pull off all the events, which we had regarded as "certainties," but also managed to score 24 points for second places. Thus the Shield returns to us after an absence of 25 years, the team scoring 84 points out of a possible 154.

Steyn put in a most brilliant afternoon's work, winning all four of the events in which he competed, and yet we are glad to be able to record that our success was by no means a one-man show. Eight members of the team scored points, and we should still have won had Steyn been unable to compete. Where all did so well it would be invidious to mention one more than another, but special praise is due to Chambers, who, having run himself right out in getting third in the half-mile, and competed again in the mile, ran as second string in the three miles and finished a good second.

Judging by the noise from the Stand, the crowd consisted largely of Guy's men, among whom were a good number of the Staff.

The following won points for the Hospital:—

C. L. Steyn. 1st in 100 yards in 10 2-5 secs.; 10 points. 1st in 220 yards in 23 2-5 secs.; 10 points. 1st in 440 yards in 53 1-5 secs.; 10 points. 1st in long jump with 19ft. 7¼ins.; 10 points.

L. G. Housden. 1st in 3 miles in 15 mins. 35 secs.; 10 points. 2nd in 1 mile; 4 points.

J. Lake. 1st in 120 yards hurdles in 18 3-5 secs.; 10 points.

R. S. Chambers. 2nd in 3 miles; 4 points.

A. S. Gough. 2nd in half mile; 4 points.

C. W. Greenway. 2nd in 440 yards; 4 points.

J. Harvey. 2nd in throwing the hammer; 4 points.

R. R. Mackintosh. 2nd in putting the weight; 4 points.

Notice.

WIGMORE HALL, Wigmore Street, W.—Under the patronage of H.R.H. Princess Arthur of Connaught, Lady Bradford, O.B.E. (President), Lady Tweedy (Chairman), Lady Fripp (Chairman General Purposes Committee), and Sir George Makins, G.C.M.G., C.B., F.R.C.S. (President Royal College of Surgeons).

An Evening Concert in aid of The Royal Medical Benevolent Fund Guild will be held on Friday, July 2nd, at 8 p.m. The following artistes have kindly consented to assist:—Miss Olive Sturgess, soprano; Miss Phyllis Lett, contralto; Mr. Lloyd Chandos, tenor; Mr. R. E. Miles, bass; Miss Elsa Stamford, violin; Miss Gertrude Tomalin, reciter; Mr. Ernest Busby, piano. Chappell grand pianoforte. Tickets (tax included): 21s., 12s., 5s. 9d., and 3s., from Miss M. Ellis Rowell, 49, Beaumont Street, W.1., and Box Office Wigmore Hall.

General Purposes Committee: Mrs. Donald Armour, Lady Fripp (Chairman), Mrs. Dundas Grant, Mrs. Thomson Walker, Mrs. Tilley, Mrs. Woodwark, Lady Gladys Edwards (Hon. Treasurer Father Xmas Branch), Mrs. Liveing (Chairman of Visiting Committee), Mrs. Henning Belfrage (Chairman of Clothes Committee).

Hon. Treasurer: Mrs. Scharlieb, M.D., M.S., C.B.E., 149, Harley Street, W.1.

The Royal Medical Benevolent Fund is an old-established institution, and is the chief medical charity in existence. It has done much good work in providing annuities for the necessitous relatives of those medical men, who, in the practice of their profession, have lost their health or their lives before they have been able to make adequate provision for their dependants.

The Guild, or Ladies' Branch, was formed about ten years ago to supplement the work of the Fund, by visiting and other personal service, by providing clothes and other necessities, and by assisting in the education and technical training of the younger beneficiaries.

An effort is being made to put the Guild on a sound financial basis, and at least £10,000 will be required for the Educational Branch alone. This is an important, if not the most important, activity of the Guild, whereby many children are helped, who, without timely and discriminating aid would never become useful or self-supporting members of the educated community. It is hoped to raise a similar sum for the opening of a Hostel to provide a haven of rest for some of the aged beneficiaries, to be used also as a Holiday and Convalescent Home for the Children.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Review.

The New Physiology in Surgical and General Practice. By A. Pendle Short, F.R.C.S. (Messrs. John 9s. 6d.

The first edition of this work was published in 1911, with the object of presenting to medical men and to students in general some of the recent advances in the fields of Physiology and their applications to the actual diagnosis and treatment of patients. The present edition contains little of the material set forth in the edition of 1911. There has been much omitted and many new facts added, and altogether the result has been the production of a very interesting and stimulating volume. The chapters on Deficiency Diseases and on the Growth of Bone are very good indeed. In a few pages the author sets down a number of facts, probably new to the average reader, and treats a difficult subject with the greatest clearness and simplicity of language. This being so, we were rather disappointed in Chapters IX. and XII., where the problems of pineal secretion and "mass-reflex" are treated in a most sketchy way. The author, despite his contentions in the preface, makes definite declarations on matters which are still under dispute. Thus the theories of blood-coagulation that he sets forth are by no means generally accepted; but it is perhaps this very independence of thought that makes the "New Physiology" so stimulating and fascinating a work.

Cricket.

GUY'S PAST v. PRESENT.

It is hoped that a Guy's Past XI. will meet the Present at Honor Oak Park on Wednesday, July 21st. Will those who would like to play write to Dr. A. C. Hancock, Central Hospital, Cane Hill, Surrey, as soon as possible.

GUY'S HOSPITAL v. R.A.F., UXBRIDGE.

Played at Uxbridge on Wednesday, June 9th. The ground was fast and runs came quickly, the R.A.F., who batted first, making 253 for 7, innings declared closed. The Hospital team missed their two best bowlers in Skeels and Van Schalkwijk, who, together with Shaw and Wooldridge, were absent.

Guy's opened rather badly, the first three wickets falling for 17 runs, but a fine stand was made at a critical time by Helder and Hewetson, who contributed 142 between them, the former making a capital century, which included 15 fours, and scoring very quickly. The position was improved by 55 from Shearer, and towards the close of play scoring became rapid and the game very exciting. Time was called with the Hospital two runs behind with four wickets in hand, and the game resulted in another draw.

R.A.F., Uxbridge.

Flt.-Lieut. R. Elliott, b Muir Smith ...	24
Flt.-Lieut. H. Clark, c Estment b Payne ...	31
T/O W. Fenwick, b Duncan	67
Flt.-Lieut. A. Lees, b Williams	4
T/O Croomes, b Payne	28
P. Woods, not out	51
A. Filkins, b Duncan	0
T/O A. Bayes, b Williams	31
Flt.-Lieut. K. Leask, not out	1
Extras	16
Total for 7 wickets (dec.) ...	253

Guy's.

E. H. Muir Smith, c and b ——	7
R. F. H. Duncan, b Bayes	6
T. J. Williams, b Woods	4
L. B. Helder, c Elliott b Woods	100
J. C. Hewetson, b Woods	42
G. L. Shearar, not out	55
H. Slater, b Woods	4
E. B. Corry, not out	15
Extras	18
Total for 6 wickets	251

V. R. Estment, F. R. Payne and R. C. May did not bat.

GUY'S v. CYPHERS.

Played at Honor Oak Park on Saturday, June 12th. Owing to excellent bowling the Cyphers lost 7 wickets for 105 when rain, which had already driven us in twice, fell in torrents, and stopped further play.

Second IX. playing on the same day v. Private Banks at Catford fared well before they suffered the same fate owing to the rain—dismissing the Banks for 75 owing to some good bowling by Fauré.

GUY'S v. SUTTON.

Played at Sutton on Wednesday, June 16th. The chief feature of the game was a brilliant century by G. D. Shaw, who treated us to some fine hitting all round the wicket—he was third out at 142, of which he made 100. Amongst his hits were 17 fours. V. Schalkwijk made a useful 40, and the innings closed for 203. Sutton started well, but went to pieces in the middle. The last few bastmen put up a fight, however, and at one time looked dangerous, but a timely left-handed catch by Shaw at mid-off and another a few minutes later by the same fielder, both off Muir Smith, probably gave us the game.

Scores:—

Guy's.

G. D. Shaw, c Simpson b Wheeler ...	100
L. C. Willis, c Dalby b Simpson	12
E. H. Muir Smith, run out	14
L. B. Helder, run out	11
J. Van Schalkwijk, c Trollope b Wheeler ...	40
G. L. Shearar, b Beaton	0
W. H. Willis, b Beaton	2
R. F. H. Duncan, b Trollope	13

J. C. Hewetson, c Freeman b Trollope ...	6
J. C. Fauré, not out	0
T. J. Williams, c Dalby b Wheeler	0
Extras	7
Total	205

Sutton.

A. C. Beaton, c Shaw b Muir Smith	45
D. D. Napper, b Muir Smith	26
T. J. Wheeler, c Willis (W.H.) b Schalkwijk	8
A. J. Trollope, b Muir Smith	10
J. L. Towkey, c Shaw b Muir Smith ...	26
A. Freeman, st Willis (W.H.) b Schalkwijk	1
A. Thomas, c Duncan b Fauré	12
R. S. Dalby, not out	23
A. Williamson, c Willis (L.C.) b Fauré ...	8
J. V. Simpson, lbw Muir Smith	14
W. M. Dorling, b Schalkwijk	0
Extras	15
Total	188

GUY'S v. THREE COUNTIES ASYLUM.

Played at Three Counties Asylum on Saturday, June 19th. Guy's batted first on a wicket which crumbled on top and fired after the first few overs during the morning play. The first three wickets having fallen for 14 the side collapsed. Helder tried hard to stop the procession, and played an attractive innings for an invaluable 44. After lunch Skeels and Van Schalkwijk started bowling, but Goddard and Buckley forced an early change and things went better after Fauré came on. Guy's tried again after tea, and thanks to Van Schalkwijk, who made a cheery 92 not out, and Wooldridge (34), compiled 163 for 4 wickets. The fielding on both sides was very keen, few chances being missed. The kindly hospitality of our hosts did much to sweeten a decided defeat.

Scores:—

Guy's.

L. C. Willis, c Harris b Buckley	5
T. Wooldridge, c Hunter b Albon	7
J. Van Schalkwijk, c Harris b Buckley ...	1
L. B. Helder, c Hunter b Buckley	44
G. L. Shearar, c Bryor b Albon	1
R. F. H. Duncan, c Goddard b Albon ...	0
J. C. Hewetson, c Hunter b Buckley	4
J. C. Fauré, b Buckley	1
H. Slater, c Albon b Buckley	1
P. B. Skeels, c Hunter b Buckley	0
V. R. Estment, not out	5
Extras	5
Total	74

J. H. Buckley 7 for 37.

Second innings: Schalkwijk, not out, 92; Wooldridge, 34; Duncan, 0; Estment, 6; Shearar, 12; extras, 19; total for 4 wickets, 163.

Three Counties Asylum.

H. Goddard, c Slater b Fauré	40
J. Buckley, c Willis b Schalkwijk	37
T. Saunders, c and b Fauré	8
E. Albon, c Wooldridge b Schalkwijk ...	4
H. Lester, st Willis b Schalkwijk	10
J. Woodhouse, c Duncan b Schalkwijk ...	0
P. D. Hunter, c Willis b Wooldridge	6
T. Harris, not out	35
J. Vine, b Schalkwijk	16
B. Prior, c Wooldridge b Fauré	5
H. Favell, c Duncan b Schalkwijk	4
Extras	8
Total	173

Guy's Hospital Rifle Club.

The second shoot for the "Armitage" Cup on June 16th:—

	200 yds.	500 yds.	Total
G. V. Bingay	41	42	83
G. Beamish	38	44	82
H. O. Eksteen	36	46	82
G. W. Elkington	37	42	79
E. A. Lloyd	34	40	74
G. Foy	37	37	74
			474

The third shoot took place on June 23rd:—

	200 yds.	500 yds.	Total
G. V. Bingay	47	40	87
G. Beamish	41	29	70
H. O. Eksteen	38	46	84
G. W. Elkington	40	40	80
E. A. Lloyd	45	44	89
G. Foy	44	46	90
			500

The scores now are Guy's, 1,368; Bart.'s, 1,347; London, 1,195; St. Thomas's, 1,041. The final shoot will be on June 30th.

Birth.

WACHER.—On June 13th, at 9, St. George's Place, Canterbury, the wife of W. Stewart Wacher, M.R.C.S., L.R.C.P., of a daughter.

Marriage.

GRICE-KILBRIDE.—At Spanish Place, on Wednesday, June 2nd, John William Hawksley Grice to Kathleen, youngest daughter of Dr. James Kilbride, of Athy, Ireland.

Death.

PEARCE.—On June 22nd, at 24, Queens Road, St. Johns Wood, Ella Mary, daughter of the late Rev. James Pearce.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT is a great pleasure to us—and one which will be shared by all our readers—to be able to include in this issue of the GAZETTE a photogravure of Sir Cooper Perry.

The good work that Sir Cooper Perry accomplished during the many years when he was Superintendent at Guy's, is well known to us all, and for this reason we have refrained from referring to it here. On another page, however, will be found an appreciation of the subject of our portrait, from a pen no less worthy than that of Sir William Hale White.

IT was with the greatest satisfaction, too, that we heard of the appointment of Mr. F. J. Steward to the Council of the Royal College of Surgeons. We welcome this in a general way because we think that the appointment is in the very best interests of surgery, and more particularly because once again a Guy's surgeon becomes a member of this representative body.

THE custom of the Governors and Staff dining together was revived on 29th June, with quite its old-time success. The Treasurer, Viscount Goschen was in the chair, while Sir Cooper Perry was the guest of the evening. The Chairman had the pleasant duty, during the course of the evening, of handing to Sir Cooper the album containing an illuminated address and facsimile signatures of his colleagues and co-workers at Guy's.

GUY'S men are reminded that the War Memorial Volume of the Reports is about to go to press.

Will those gentlemen, therefore, who have not yet forwarded particulars of their war service to the Secretary of the War Memorial Committee, kindly do so at once in order to make the record as complete a one as possible.

FOR several years now the position of the voluntary hospitals has been a critical one, but notwithstanding the gallons of ink that men have spilt and in spite of all the talk about ways and means, the problem remains unsolved, and only lately one large hospital has practically closed down, while another has been forced to abandon the principle of free treatment and demand from its in-patients payment in money week by week.

The situation is of interest to us all; for each one of the General Hospitals, contemplating its own uncertain position, might well adopt the words of the man in Lavengro, and say, "There—but for the Grace of God—go I."

This being so, it is, perhaps, worth while to consider here the merits of a scheme whereby the patient helps to defray the expenses of his own up-keep.

In our knowledge there are few patients—in the Borough at least—who can afford to pay as much as one pound a week for their maintenance at hospital, more especially when the patient is, himself, the breadwinner of a family, and although it would be possible to prevent the very poor from suffering undue hardship by establishing a system of careful inquiry, the expenses involved thereby would be considerable.

It is conceivable that those patients who were taken into hospital for the treatment of an acute illness, would foot their bill cheerfully enough. But the patient who was offered a bed for purposes of investigation, might well be deterred from taking advantage of his opportunity by the expenses incurred under the new scheme. In the same way the parents of a patient suffering from a disease like acute rheumatism would hardly relish paying for three or four months' of treatment and might be sorely tempted to remove their child from hospital before the condition was cured or even checked.

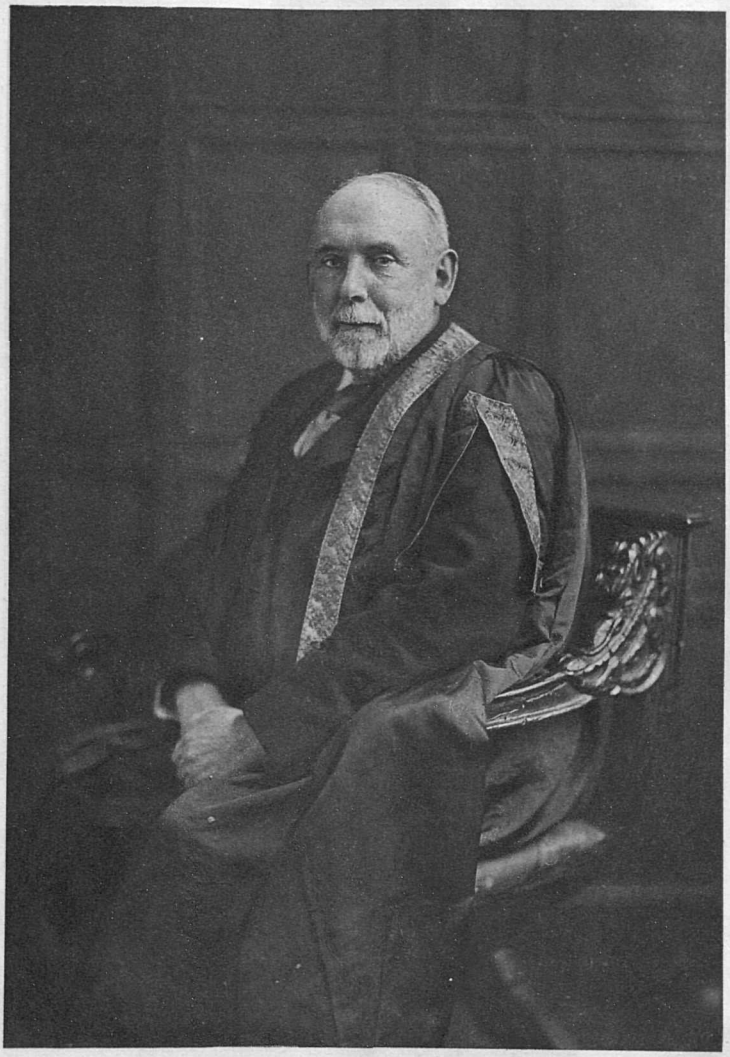
It would seem, therefore, that the adoption of a scheme whereby the patient pays, unavoidably results in some limitation of a hospital's sphere of usefulness. It is a great pity that the public is unable to provide, through voluntary contributions, a sum of money sufficient to make such a course unnecessary. At present the only alternative to it, is "State Aid." When one is situated between the Devil and the Deep Blue Sea, the scope for choice is small.

THE whole question of professional secrecy has recently been considered by the Ethical Committee of the British Medical Association.

The answer to the question: "Should a doctor tell," is of course a difficult one and there are many people who still hold that under no circumstances should a medical man disclose knowledge gained in the course of a consultation. Now such an unequivocal attitude does not provide a logical solution to the problem.

Thus in the hypothetical case quoted by the Solicitor to the Association where "the doctor knew that a man suffering from venereal disease was to be married to an innocent girl—the daughter of a friend of his"—we fail to see how any medical man could do otherwise than prevent such a marriage, by any means at his disposal. This example is, perhaps, an unfortunate one to choose, because in it the patient is stated to be suffering from venereal disease. Provided that it be serious and contagious, the actual nature of the disease from which the patient is suffering, and its ætiology is of no account at all in the ethics of the case. Of course it is only under very exceptional circumstances that a medical man has any right even to think of divulging a professional secret, and if he *does* break faith with his patient, we think that he should be ready to account for his action before a special Ethical Committee, if necessary.

But one must remember that the terms "good" and "bad" are not fixed and unelastic; they are purely relative: An action is right if it benefits mankind; on the other hand it is wrong if it is contrary to the welfare of society. It is obvious that if medical men become less reticent than they are at present, people will be less willing to consult them, and the early diagnosis of disease is likely to be merely a visionary ideal. Nevertheless, where the welfare of a third party is threatened by the foolishness or selfishness of a second, we



E. C. Perry.

think that it is the duty of the first party—the doctor—to step in and prevent injustice, if he can.

POSTED about the Hospital and printed on another page of the Gazette is a proposal by the Council to increase the membership subscription of the Clubs' Union from three to five guineas.

The statement in question is, we think, so clear and indisputable as to leave little room for comment here. For it is obvious that increased expenditure implies a corresponding increase of income: either the extra amount of money that is required must be found, or the many advantages that the student derives from the Clubs' Union must be lost to the present generation.

Even before the war, three guineas a year was a small sum to pay for the numerous attractions that the Clubs' Union provides for its members.

Now, with the cost of labour and materials increased by a hundred per cent. and more, we are sure that no one will grudge the extra two guineas that the Council considers necessary for the maintenance of the club and for the introduction of necessary improvements, both in the College and down at Honor Oak Park.

ON 30th April, 1920, Guy's was defeated in the semi-final of the Cricket Cup Tie by a Middlesex Hospital team. Faced by a score of 375 our side succeeded in knocking up nearly two hundred runs against some excellent bowling, and although beaten by a better side, our team had every reason to feel satisfied with a very sporting display.

However, we were pleased to observe that the shooting team has been successful in winning the Armitage Cup, and we hope that equal success will attend the efforts of the Tennis Club in the immediate future.

Sir Edwin Cooper Perry.

IN the year 1887, four of the active physicians, or assistant physicians, at Guy's had recently died, and one had become consulting physician. The Governors, therefore, asked the staff to recommend for election three assistant physicians. One of those chosen was Cooper Perry, who at that time was just finishing his house-physiciancy to Sir Stephen Mackenzie at the London Hospital, having already been house-surgeon to Sir Frederick Treves. He was known as having been Captain of Eton and Senior Classic at Cambridge. He was a Fellow of King's, he had already shown his versatility by studying music to such good purpose that he had prepared a new Anthem Book, and any one attending service at King's College Chapel now will see by the title page that the Anthem Book he edited with Dr. A. H. Mann, the organist, is still used. He had been a student of Philosophy in the University of Leipsic, and, lastly, turning his attention to medicine, his abilities had also shone there. The Staff rightly said: "the man who can do all this must have such an exceptional mind that he will be an ornament and an accession of strength to Guy's, therefore, although so young in medicine, we will recommend him." Never has the wisdom of a choice been more abundantly justified, for it quickly became clear that Guy's had secured a great teacher, a born administrator, and a highly skillful organiser. Time has shown that from the first day he arrived in St. Thomas's Street down to the present he has unselfishly and continuously devoted his brilliant energies to the benefit of the Hospital and the School.

Many hundreds of students can testify to his power to teach, whether in the post-mortem room, the wards, or the out-patient department. Crowds flocked to hear his demonstrations on cutaneous diseases, keen was the competition to be his ward clerk.

The GAZETTE of November 29th, 1919, applied to Sir Cooper the famous last four words of Wren's epitaph over the northern entrance door of St. Paul's. None more appropriate can be found. The Hospital and the School as they stand now are indeed a monument to him. Both have been so improved by him

that the student who was at Guy's before 1888 hardly knows where he is when he revisits his training place.

Perry was Dean from 1888 to 1893; the time was ripe for his administrative and organising genius. The higher appointments of house physician, house surgeon, and dresser had hitherto been given to a select few who were much overworked, and many students fully deserving these appointments were unable to obtain them. The whole system was altered during Perry's term of office, the number of dressers was increased, and each member of the Staff was given his own house physician or house surgeon. As Sir Cooper said in the paper he wrote in the Guy's Hospital Reports, an oligarchic became a democratic system. The history of Guy's shows that for more than fifty years a Residential College had been desired by the authorities, a piece of land fell vacant, and the present College and Students' Club, the first of their kind, were built upon it; thus it became possible to accommodate the additional house officers. The thirteen new residents went into the College in March, 1890, and Perry was installed as Warden, a most fitting appointment, for he was, more than anyone, responsible for the building of the College.

The earliest lectures on dentistry, at any medical school in England, were delivered at Guy's Hospital by Joseph Fox over 100 years ago, he was succeeded by the famous Thomas Bell, but although lectures were given and teeth extracted, the science and art of dentistry were neither practised nor taught. In 1888 it was proposed to attach a Dental Hospital and School to Guy's; Perry threw himself with enthusiasm into the scheme, and the present magnificent dental out-patient department and school are the result of this enthusiasm.

He did not lose any of his interest in the Medical School when he ceased to be Dean, he has been continually evolving projects for its improvement, and by his infinite painstaking, his example and his counsel helping the plans of others. During the time he has been with us the new Medical School buildings have arisen, the Wills' Library has been built, the pathological block, the bacteriological block, and the Gordon Museum have sprung into existence, and the endowments of the School have increased.

In 1892 he became Superintendent. It was a new experiment for this post to be undertaken by a member of the Staff, but as Guy's benefited greatly by appointing him physician, it has also gained enormously by having him as superintendent. It has been pleasant for the Staff to have one of themselves to whom they could talk about the affairs of the Hospital. The transformation and improvement of it since he became Superintendent have been marvellous. Fortunately for him, he has had in Mr. Cosmo Bonsor a Treasurer whose continual object has been to make Guy's as fine a hospital and school as possible, and who has always with wisdom, judgement and fervour aided anyone who would help him to attain this end. Schemes developed rapidly in Sir Cooper's fertile mind, operating theatres sprang up on the site of old Esther ward, and later, on the top floor in place of old Samaritan ward, a large, entirely new out-patient block was added at the end of the Medical Building, the old front surgery and dressers' rooms became an electro-therapeutical department, lifts appeared in the surgical and medical buildings, and all the wards were modernized, a department for massage and remedial exercises grew on the top of the medical building, even whirlpool baths made their appearance, a venereal diseases clinic was opened, X-ray rooms and medical clinical laboratories were built, a new children's welfare centre, a tuberculosis department, and a ward for infants are now to be seen. Lastly, and greatest perhaps of all, the putting of clinical and other wards on the top of the Medical Building has been taken in hand, for, on the site of John ward, the extension of the Nurses' Home to accommodate the extra nurses required by the new wards has been begun.

The Superintendent has always been to the front in helping the welfare of the nurses. It is doubtful if there is a finer nursing home in the world than the Raphael Home at Guy's, this, too, owes much to him. The Salomon centre of infant and mother welfare, which is largely an offspring of his foresight, will shortly be opened in Newcomen Street, and, like the Students' College and the Nurses' Home, will doubtless be a model for similar institutions elsewhere.

One of the most remarkable things about Sir Cooper is, that although he can evolve rapidly and most successfully large plans of

reconstruction, yet he can also pay attention to minute details. We have given many examples of the first characteristic, one will suffice of the second. It is well known that although nominally the last three editions of the Guy's Pharmacopœia were prepared by a committee, all the tedious labour of correction of proof and arrangement of details were the work of the Superintendent, and certainly a better Hospital Pharmacopœia does not exist.

No man has ever been less guilty of self advertisement than Perry, it is foreign to his whole nature; but such striking powers of administration and organisation could not long remain hidden, and they soon became known far and wide. The first Lord Cromer, through the Government, applied to the College of Physicians to send some one out to Cairo to organise a medical and a pharmaceutical school for Egypt. The College sent Sir Cooper, the work was quickly and well done, it has not been found necessary to alter the principles he laid down many years ago.

After the South African War the Government decided that improvements were needed in the Army medical service, and appointed a Committee to formulate the desirable changes, and to make suggestions for the best way of adopting them. Perry was one of the most active members of the Committee, the advice of which was followed, to the great benefit of the R.A.M.C. For this he received a Knighthood. There was a fierce internal dispute in the hospital of one of the largest towns in the North. Perry was requested to go and hold an enquiry and to act as arbitrator. This he did, and after his judgement the discord died down. For many years he has been a member of the Distribution Committee and of the Council of King Edward VII.'s Hospital Fund. He was always active in furthering the cause of state registration of nurses. He has been one of the moving spirits and one of the hardest workers in the founding of the College of Nursing, of which he is now the Honorary Secretary.

After the reconstitution of the University of London in 1900, Perry was one of the first three representatives of the Faculty of Medicine on the Senate, and in this capacity he served for five years. In 1915 he was returned at the head of the poll as member of the Senate of the University of London, becoming Vice Chancellor in 1917, a post which he now leaves, after two and a-half years' tenure, for that of Principal Officer. Surely no one could have worked harder for the public good and less for his own advancement than he.

But, apart from all these activities, the results of which everyone can see, he has been, ever since he came to us, the adviser and helper of anyone in difficulty or trouble who has been wise enough to apply to him; always ready to listen, to go thoroughly into the subject, and to give generously his time and his advice. Thus it comes about that all of us who are or have been at Guy's not only respect and admire him, but feel for him an affection which will endure as long as life lasts.

Pass List.

Royal College of Surgeons of England.

F.R.C.S.

The diploma of Fellow has been awarded to the following:—

W. H. Ogilvie. C. S. Lane-Roberts.
J. Joffe.

FINAL EXAMINATION: L.D.S.

Part I., May, 1920.

D. M. Desai.	F. J. Downing.
T. D. Wille.	W. Krige.
C. A. Marais.	L. Lyon.
H. Ashling.	E. H. Muir-Smith.
H. G. R. Canning.	S. P. Meacock.
A. C. Ayling.	B. C. Woodroffe.
H. A. Coysh.	F. D. Neal.
H. J. Hooker.	A. T. Partridge.
F. W. Day.	J. W. E. Warren.
D. T. G. Dickins.	S. W. Southwood.
C. D. Dorward.	G. M. Stuart.
I. Freiberger.	H. C. Tweney.
J. J. Du Tait.	S. W. A. Davis.

Part II.

*D. M. Desai.	*A. R. Cox.
*C. A. Marais.	*N. Gerson.

*Awarded Diplomas.

Hoarseness.

BY W. M. MOLLISON, M.Ch., F.R.C.S.

(*Continued.*)

Let us now pass to the consideration of Hoarseness due to changes in form of the larynx. These changes may be grouped under four headings: (1) Congenital, (2) Traumatic, (3) Growths, (4) Inflammatory.

(1) Congenital webbing is sometimes seen; the anterior parts of the vocal cords are joined together by a thin layer of tissue having a posterior edge, which is concave; the glottis is thus made much smaller than normal, and some inspiratory stridor is present as well as hoarseness.

(2) Traumatic. Wounds of the larynx may involve the vocal cords, and the damage done changes the form of the larynx; the subsequent scarring, too, produces all sorts of distortion. Apart from war, wounds of the larynx are rare.

(3) Growths of the larynx may be *innocent* or *malignant;* they occur in any part: epiglottis, aryteno-epiglottidean folds, arytenoid region, and vocal cords. *Innocent*, the most common are *papillomata;* they occur in young children in the form of warty outgrowths on the true cords more towards the posterior than anterior ends, often multiple; they are also seen on the epiglottis. Hoarseness is a marked symptom, and dyspnœa may be so severe as to demand tracheotomy. In the museum are several specimens, and it is interesting to notice that the papillomata have seeded themselves in the tracheotomy wound and in the trachea. Removal is often followed by recurrence and repeated operations have been needed till about puberty, when the tendency to recurrence ceases.

Many other kinds of innocent growths occur, many of them rare. In the museum is a specimen showing a *cyst* of the epiglottis. Some two years ago we had a case of cyst in the ary-epiglottic fold in the hospital. A girl of 8 was sent with the history of slight hoarseness and slight dyspnœa for some years; she had twice had adenoids removed on this account. Examination showed a smooth pale swelling of the left aryteno-epiglottidean fold, so large as to overhang the glottis. By using suspension laryngoscopy this cyst was operated upon; it was found to have a very thin wall, and an attempt at removing the whole cyst failed. The patient was much improved till two months ago when she was found to have a recurrence. Operation was again undertaken, but it was not found possible to do more than incise the swelling and evacuate the contents, which consisted of a thick, grey mucus-like material.

Fibroma, lipoma, adenoma and *angeioma* are met with. Recently I saw a nurse who for a year had been hoarse; examination showed a small red tumour on the right vocal cord; this was removed very easily through a Hill's laryngeal tube, and proved to be a vascular growth on microscopical examination.

Not long since a man of 38 attended in the Out-Patient Department on account of some nasal symptoms; routine examination by the dresser showed a smooth swelling of the left ary-epiglottic fold. On inquiry the patient said he had attacks of dyspnœa now and then, and his voice was slightly thick. With the aid of suspension laryngoscopy a solid tumour was dissected out through an incision in the mucous membrane over the swelling. Microscopically this proved to be a fibroma with a few necrotic patches.

Malignant growths are usually epitheliomata, occasionally sarcomata. Epithelioma occurs on the true vocal cord as a sessile, warty-looking growth; it may occur on any part of the cord and tends to spread forwards and backwards; by infiltration the movements of the cord are diminished and hoarseness is a prominent and early symptom. Hoarseness in a man (it is commoner in men than in women) over 50 with no previous history of attacks should make one suspect epithelioma even though the laryngoscopic appearance does not show a projecting growth. If epithelioma is diagnosed, early operation holds out every chance of success, because the epithelioma is very localised and does not cause gland infection till late in the disease.

The appearances presented vary from a localised redness with very little swelling of one cord, to a projecting warty growth which may be pale. The cord's movements may be almost normal, sluggish or absent. Recently I saw a patient of 60 who for four months had been hoarse; examination of the larynx showed almost complete fixation of the left vocal cord with a little redness,. At a second examination a small projection was seen at the anterior commissure. The larynx was removed by operation, and showed a flat epitheliomatous

infiltration of the cord and a slight projection in the anterior commissure, the growth having spread forwards and involved the opposite vocal cord. In a case of this sort the diagnosis must lie between growth, syphilis and tubercle, and in any doubtful case of hoarseness the last two must be excluded before operation is decided upon.

Carcinoma may occur in other parts of the larynx. In one case I saw, there was a small warty epithelioma on the upper edge of the epiglottis. In other cases the ary-epiglottic fold is the site of the growth. This will cause only slight thickness of the voice and perhaps some pain on swallowing, and early diagnosis is seldom possible as patients do not present themselves for examination soon enough.

Advanced cases of carcinoma of the larynx are comparatively easy of diagnosis. Large ulcerating masses overhang the glottis; growing from the cords, or arising from the epiglottis the mass hides the larynx.

These cases of growth arising in the larynx —the so-called intrinsic carcinoma—are to be distinguished from growths arising outside the larynx and invading it. These are the so-called intrinsic carcinoma, but they really are pharyngeal growths and often originate in the pyriform fossa. They give rise to hoarseness or thickness, but, in addition, to difficulty in swallowing.

(4) Inflammatory. In a previous section we considered inflammations as producing changes in colour of the larynx, but some forms produce changes in form more marked than changes in colour. Syphilitic hyperplasia of the interarytenoid tissue is seen and the mass formed is so large that the normal slight concavity at the posterior end of the glottis is changed to a convexity. This condition is called pachydermia laryngis.

Another condition that gives deformity is syphilitic perichondritis. This is a gummatous infiltration under the perichondrium of any of the cartilages. When the thyroid cartilage is involved, the swelling shows in the region of the false cord, hiding the true cord; this leads to hoarseness and some dyspnœa; the swelling also occurs on the outer surface of the thyroid and shows in the neck. The arytenoid may be the affected cartilage; this leads to enlargement, and fixation of the crico-arytenoid joint may follow.

The third section deals with changes in movement of the cords; this leads to a consideration of fixation of the cords or of one cord and paralysis of one or both cords. Clinically the result is weakness of the voice rather than hoarseness. *Fixation* of one cord has been touched on; it is due to any lesion limiting the movements at the crico-arytenoid joint; this may result from acute inflammations which lead to ankylosis; it is seen in some of the acute fevers, notably scarlet fever; when it attacks children, recovery of the vocal function may be almost complete. A nurse complained of slight hoarseness. Examination showed complete fixation of the left cord due to fixation of the arytenoid; there was no sign of inflammation, and inquiry elicited the fact she had had symptoms since an attack of scarlet fever when a child; the right vocal cord had been educated to overact to such an extent that it met the inactive left cord so well as to produce an almost normal voice.

Just above I mentioned syphilitic perichondritis as causing fixation of one cord; since this condition comes on in adult life, compensation is not complete and hoarseness always results. Anti-syphilitic treatment often cures this and movement is restored to the joint.

Growth may cause fixation by infiltration of the tissues about the joint; carcinoma may begin in the hypopharynx, especially in women between 35 and 45, and spreading upwards may lead to fixation of one or both crico-arytenoid joints. Similarly, growth in a pyriform fossa may be the cause of the fixation.

Paralysis may be organic or functional. Before dealing with this section, just a word on the mechanism of the movements of the cords. Simply stated, the cords are attached anteriorly to the re-entrant angle of the thyroid cartilage, posteriorly to the vocal process of the arytenoid cartilages. The arytenoids articulate with the upper surface of the posterior part of the cricoid ring. Movement at this joint is of two kinds—inwards and outwards, and rotation on a vertical axis. The arytenoids may be considered as triangles, the anterior angles represent the vocal processes and the outer angles the muscular processes; to the latter are attached muscles. The muscle that pulls the muscular process inwards pulls the cord outwards, this muscle is the posterior crico-arytenoideus or "posticus" muscle; in other words, it is the abductor muscle. If it is paralysed an abductor paralysis is said to be present. To adduct the

vocal process the muscular process is pulled outwards by the lateral crico-arytenoideus. Both sets of muscles are supplied by the recurrent laryngeal nerve, but if the nerve is paralysed the abductor muscles are always affected first. This is a most important point; expressed clinically abductor paralysis, *i.e.*, inability to abduct the cord always indicates an organic lesion. Functional paralysis always affects the adductors; thus when examination of the larynx shows the cords moving outwards during inspiration, but failing to meet on phonation, a functional affection is certain.

In the later stages of organic paralysis all the muscles will be paralysed and the cord will take up a flaccid position half-way between adduction and abduction—the so-called cadaveric position.

Paralysis of the recurrent laryngeal has usually a peripheral cause, though central affections also occur. A consideration of the anatomy of the two recurrents gives the clue to the causes of paralysis; you will remember that the left nerve passes down into the chest, winds round the arch of the aorta and returns to the neck and so to the larynx; the right nerve winds round the subclavian artery. Both lie in relation to the thyroid gland and near the œsophagus.

Let us consider some of the causes of paralysis: the left nerve is more often affected than the right; aneurysm of the aorta is a frequent cause; growth in the mediastinum; glands in the mediastinum and in the neck; growth of the thyroid; growth of the œsophagus. On the right side the same causes hold, substituting aneurysm of the subclavian for that of the aorta. Paralysis of the right cord combined with any difficulty in swallowing is almost diagnostic of carcinoma of the œsophagus.

Sometimes both cords are paralysed—double abductor paralysis; the voice is then very weak and is accompanied by attacks of dyspnœa because the glottis cannot be opened on inspiration; the reasons for this are more often central than peripheral; it occurs in tabes and indeed may be the earliest sign of tabes. Growth of the mediastinum may involve both nerves, and so produce the double abductor paralysis.

Lastly, *wounds* of the recurrent nerve occur, bullet wounds in the neck and at the base of the skulli nvolving the vagus, and of the chest. At Queen Mary's Hospital I saw a most curious case of this last: A sergeant was wounded by a bullet that entered just below the second rib on the left side; he at once found he could not shout. Examination of the larynx showed paralysis of the left cord, and X-ray examination of the chest showed a bullet lodged exactly in the concavity of the aortic arch where it must have damaged the nerve on its way round the arch. Another man was wounded by a bullet entering just below the right ear; he had paralysis of the right half of the tongue, the palate, the right side of the pharynx, and the right vocal cord. X-rays showed the bullet at the base of the skull where it had damaged the 9th, 10th, 11th, and 12th nerves.

Functional paralysis always affects both cords. Patients complain of weakness of the voice or of loss of voice, being able to whisper only. These patients, as a rule, can cough normally, yet when the larynx is under observation the cords show but slight adduction on attempted phonation. Persuasion usually results in cure in a few minutes. In some cases the anterior parts of the cords are brought together, but the arytenoids are not approximated so that a small triangle is left at the posterior end of the glottis. As you know, the number of cases of functional aphonia and functional dysphonia brought about by war strain was very great; many of them showed reddening of the cords due to misdirected efforts at speech, and this redness disappeared in a day or two after they had been persuaded to speak properly.

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The Treatment of Compound Fractures.

CLINICAL LECTURE BY E. G. SLESINGER, M.S.

GENTLEMEN,—I have taken the subject of the treatment of compound fractures for our consideration to-day because it is one of the branches of surgery in which the war has taught us a great deal, and unless we learn to apply that knowledge to cases as they occur in civil practice there is a danger—and I believe it is a very real one—that what we have learnt may only too easily be forgotten, and we may fail to give our patients the benefit of the unique experience which the war unfortunately put into our hands.

In considering the treatment of a compound fracture it is quite clear that we have to deal with two separate questions, that is to say, firstly, we must treat the wound which of necessity exists, and secondly, we must treat the underlying fracture; and although these two phases of the question are interdependant, it will be better to discuss them separately.

Firstly, in regard to the treatment of the wound itself. Here everything will depend on the all important time factor, upon whether we can operate on our patients before an *infected* wound has had time to become a *septic* one. Just where the dividing line is, it is hard to say, and it probably varies in different cases, but I think it is a fairly safe working rule to consider a wound within six hours of its receipt merely as an infected one, and to look on the same wound after eighteen hours as certainly septic in the case of compound fractures. Cases seen in the intervening period will vary according to the severity of the injury and the nature of the contamination. Supposing that we get our case within six hours of the injury, what is to be our line of treatment? I think the war has shown the proper answer to that question; it is excision and suture which, if successful, will have converted a compound into a simple fracture. By excision is meant a complete and thorough removal of all infected or injured tissue, including bone, and as far as possible in one piece and without re-infecting the wound in the process.

This operation in the case of a compound fracture is often very difficult, and in performing it the greatest care must be taken to remove every particle of injured tissue, and to realise that the tissues we are removing are infected, so that it is only too easy to re-infect the clean bed of the wound unless a very careful technique is practised. I would warn you against using a tourniquet in these cases, as I am convinced that tissues already damaged may easily have their powers of repair tried too high by being deprived of their blood supply for a considerable time.

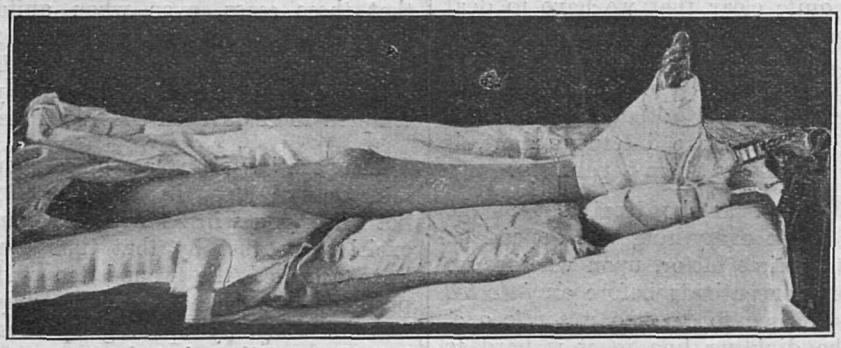
After a complete excision in a case operated on within six hours it is usually safe to suture the whole wound, but in most cases it is not wise to plate the fracture. Such an excised wound is probably not perfectly free from organisms, which, although the body can successfully deal with them in the ordinary way, are liable to get the upper hand in the presence of a foreign body. It is worth remembering that these cases, even when quite successful, often show a rise of temperature for the first two or three days, up to 102° or 103°, so that unless you are aware of this fact you may be tempted to remove stitches needlessly.

In operating on a case of compound fracture later than eighteen hours after the injury, I do not think you will be wise to attempt complete excision, because by that time organisms will have attacked the wound too widely for the proceedure to succeed, and you may only make matters worse by opening up fresh planes to infection. There has been great controversy as to the best method of dealing with these later cases, some advocating antiseptics of one kind or another, and others being as strongly opposed to their use. Personally, I cannot conceive how any antiseptic can be expected to reach organisms from which it is probably separated by a considerable layer of dead or dying tissue, and I do not believe in using them. What you want to do is to remove from the wound every trace of dead tissue, for if you can do that, organisms will disappear at the same time, and your wound will be ready for late closure. There are many methods of trying to get rid of dead tissue, and from what I have seen, I believe the simplest and best method is for the wound to be or to become infected with the maggots of the ordinary blue-bottle fly. These maggots will remove dead tissue at an enormous rate, and, what is most important, without injuring the living cells in the process. Wounds which they inhabit are

changed in a period of from four to five days from a foul sloughing condition to a bright red granulating surface in quite a remarkable way, and but for its supposed æsthetic disadvantages, I am convinced that this method of treating infected wounds is by far the best that I am aware of. If for one reason or another maggots are unsuitable or unobtainable, the next best line of treatment is by the Carrel-Dakin method. This consists of intermittent irrigation of the wound through Carrel's tubes with Dakin's solution, that is to say, a neutral solution of hypochlorite of soda of a standard strength. Most of the so-called Dakin's solution I have seen in use since the war is not Dakin's solution at all, and obviously in order to get results you must use the proper solution. The way in which this solution acts is that it rapidly splits up insoluble and soluble protein materials into the lower amino acids, the changes that occur being just as complete and considerably more rapid than in the case of tryptic digestion, and at the same time the fluid is sufficiently antiseptic to prevent any further bacterial growth. It is essential so to plan the original cleaning operation, that the solution can be brought into contract with each and every part of the wound, and to arrange the Carrel tubes with that object. The different pressures needed to cause a flow from the superficially and deeply-placed tubes equally, are equalised by having them with differing numbers of holes, few holes for the deep tubes and many for the surface ones.

If the patient comes to operation at any time between six and eighteen hours after the injury, I think it is wise to practise what has been termed delayed primary suture. In such a case a careful and complete excision of the wound is performed at once, and the cavity so formed is packed fairly firmly with plain sterile gauze. It is left like this for 48 hours, at the end of which time an anæsthetic is given, and the gauze removed. If the wound now looks quite clean, complete suture can be carried out at once, and, on the other hand, if it is seen that the excision has failed and sepsis is present, the treatment with Dakin's fluid can be begun. In a doubtful case considerable help can be got from examining a film from the surface of the wound. Bacilli of all kinds must be treated with great respect, and cocci in groups or chains, and if either is present suture should be delayed. Single cocci, however, need not interfere, as the tissues can be safely left to deal with them themselves in most instances.

FIG. I. Finochietto's Stirrup.



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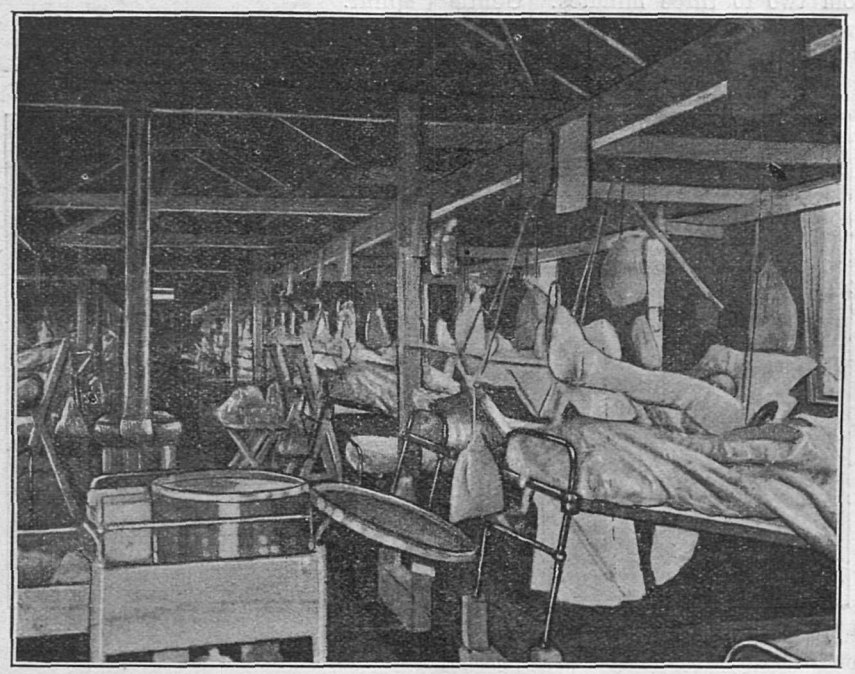
So much, then, for treatment of the actual wound; what we must now consider is the treatment of the underlying fracture. It is an interesting fact, though not very easy to explain, that the better the anatomical reposition of the fracture, the less likely is the sepsis to be severe, due no doubt largely to the proper alignment of lymphatics, etc., which automatically results. In the case of a compound fracture it is often much easier to secure good position than in a simple fracture, the reason being that the longitudinal ties of the bone, which being shortened by effusion, prevent reduction in a simple fracture, are usually torn in a compound case and no longer offer any obstacle to reduction. What we have to do then is, firstly, to reduce the fracture and, secondly, to main-

tain it in its position by suitable splints and extension.

To securing extension in most cases, the best method is undoubtedly gauze in some form fixed to the skin by Sinclair's glue. This glue should always be applied with the surgeon's own ungloved hand, as I think a great many of the cases of blistering which occur with it are due to the glue being put on with a brush, and therefore far too hot. When the fracture is in the lower limb, I think a very great responsibility rests on the dresser and house-surgeon in the surgery and on the nursing staff in the wards. Nothing could be worse for such a case than the examinations, the undressing, and the washing to which it is too often subjected before coming to the theatre. War experience has shown that the proper way to deal with such a case is to make a diagnosis with the minimum of observation, and once it is made, which is usually very simple, to leave the limb alone, with trouser, boot, and sock still on, and to slip a Thomas' splint carefully over and to apply extension by putting a clove hitch of bandage over the boot, and tying it to the end of the splint. In this splint the patient is taken to the ward, where *nothing* should be done to him except to warm him up and otherwise resuscitate him, until ready for the theatre, where undressing, cleaning, operation, and splinting can all be done at once.

In the great majority of lower limb fractures the most satisfactory splint is the Thomas, used on the Hodgen principle, that is to say, suspended by a counterbalance from overhead, and with a running weight supplying extension.

FIG. II. Bent Thomas' Knee Splints slung on Hodgen Principle.



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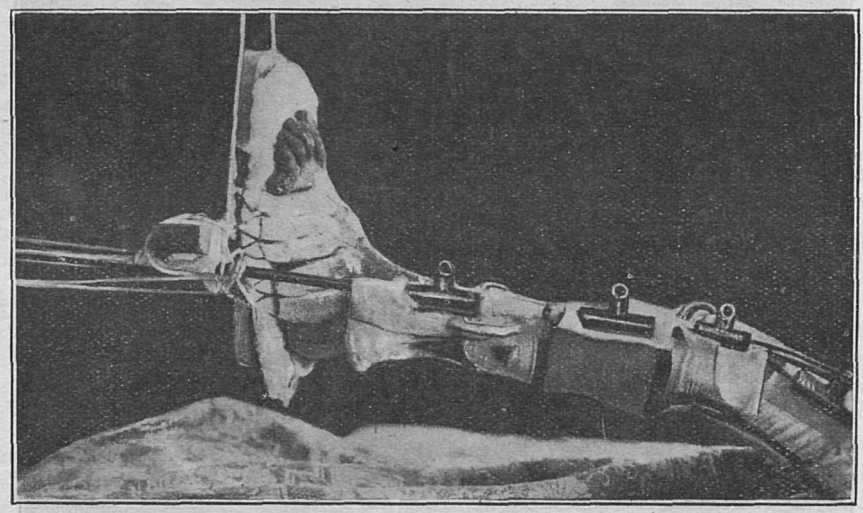
Counter-extension is obtained by raising the foot of the bed, but it must be raised very considerably, the usual six inches being, practically speaking, quite useless. For most fractures of the femur I think a bent Thomas' splint is best, movable at the knee, and with a metal archway fixed to the splint by strapping in the required position, from which the foot is suspended by gauze glued to the sole. Extension is obtained by gauze glued to the leg and fixed to the bottom of the splint, or if that is not sufficient, by some form of calliper driven through the skin and gripping the condyles of the femur.

The leg is put up in this splint by means of slings of flannel running from bar to bar. They are fixed to the inner bar, and can easily be adjusted to the outer bar by means of a somewhat powerful form of paper clip. The best method of reducing such a case is, first, to fix the sling, which comes under the lower end of the upper fragment, and then by using this as a lever and pulling on the leg, the fracture can be reduced and maintained in position by adjusting the other slings. If large sterile pads are used, which will wrap right round the limb, all the inconveniences of bandages, etc., can be avoided, and the dressing becomes a matter of from two to three minutes. Gentle movements of the knee-joint, by means of the hinge in the splint, can be begun in about two weeks, and the position of the fragments should be controlled from time to time by plates taken with a portable X-ray machine.

In regard to the bones of the leg, the splinting will depend on the type and position of the break. Transverse and badly comminuted cases do very well with a Thomas' splint and Sinclair's footpiece.

The latter is a flat piece of half-inch wood, with serrated edges, and a little larger than the sole of the foot. It has a vertical slot in the middle to which is attached, by means of a fly nut, a transverse piece of metal. The foot is fixed to it by means of tapes attached to little metal triangles threaded on strips of ribbon gauze glued round the foot. The crosspiece rests on the bars of the Thomas' splint, and by adjusting the fly nut, any position of the foot in regard to the long axis of the splint can be obtained. The fracture is reduced by traction and manipulation, and fixed by strapping the crossbar of the footpiece to the bars of the splint in the necessary position to maintain reduction, the slings on the Thomas' being then adjusted accordingly. The upper fragment should be steadied by strips of gauze glued to the thigh and tied to the bars of the splint.

FIG. III. Bent Thomas' Splint, slung on Hodgen Principle, with Sinclair footpiece (for Compound Fracture of Tibia.



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This method, however, is not very satisfactory for long oblique fractures, or for fractures of femur or tibia running into the knee-joint. The latter, which are always difficult cases, do best, I think, with a very considerable extension and early and continued mobility. A good way of attaining these objects is by means of what is known as Finochietto's stirrup. This consists of a flat piece of steel, which is passed over the upper surface of the os calcis, in front of the tendo Achillis by means of an introducer. To its two ends a stump is attached, and both it and the foot are swathed in bandages, care being taken to keep the foot at a right angle. No splint is necessary. The patient is encouraged to perform active movements from

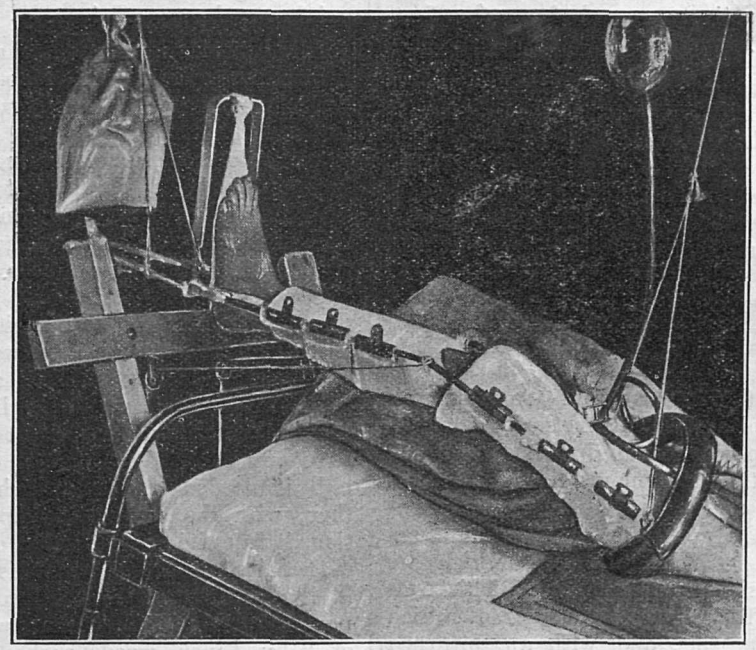
the first, which, with a weight of 10 to 12 lbs on the stirrup, are usually quite painless. I do not think this method is safe in the case of septic fractures in the lower third of the leg, as the risk of a spread of infection to the small stirrup wound is too great.

In the case of long or short oblique fractures of the tibia, reduction is often very difficult to maintain, the fragments slipping out of position as fast as they are replaced. Such cases are often very troublesome, and I believe the best method of dealing with them is to fix the fracture by means of a plate and screws, and to leave the wound widely open. The plate can then be removed at the end of about three weeks, when the fragments will no longer tend to displace.

Fractures of the tarsus and metatarsus can be dealt with by suspension from an archway by gauze glued to the toes, the leg, in a Thomas's splint, being kept in position relative to the foot, by gauze running from the leg to the bottom of the splint.

In the case of compound fractures of the upper limb, the treatment will depend very largely upon whether or not the case is seen early enough for primary excision and suture to be practicable. If it is, and if primary union results the splinting will be largely the same as in the case of simple fractures, and in the forearm, it is often the best plan to wait for three or four weeks after such an excision and then to plate the bones in the usual way, particularly if both bones are involved at approximately the same level. If on the other hand an upper limb fracture is seen too late for excision and suture, or if this method has been tried and failed, I believe it is best to keep the patient in bed for the first two or three weeks and treat them with some method of suspension-extension. Where the fracture is of or near the head of the humerus a good position is often best maintained without any splint and by merely placing the forearm in a sling, the elbow being fixed to the side of the chest by strapping and bandage. Fractures of the shaft of the humerus in its middle two thirds can be treated in one of two ways, depending on the situation of the wounds in the soft parts . In cases where there is sufficient intact skin, a form of suspension-extension without a splint gives ex-

FIG. IV. Bent Thomas' Knee Splint slung on Hodgen Principle.



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cellent results. Glue is applied to the front and back of the forearm, and gauze strips are fixed to it, while similarly gauze strips are glued to as great a surface of skin over the lower fragment of the humerus as possible. A mackintosh is applied over the dressings round the fracture, and suspended by a cord which, running over two pulleys in an overhead bar, has its other end attached to the gauze glued to the forearm. The necessary weight to secure counterbalance is attached to the cord between the pulleys. The gauze from the lower end of the arm is fixed to a cord running over a pulley at the end of the bed to which the required extension weight is attached. This method gives excellent results, and all the joints can be actively moved from the first.

If the skin is too extensively involved for this method you can use an arm Thomas's splint bent at right angles and made to fit over the shoulder. You can get extension in this splint by using the forearm as a lever. You fix the wrist to the inner bar and then by pulling the upper forearm to the outer bar you make traction in the line of the humerus. In suspending this splint the centre point of suspension must be external and in front of its centre to prevent undue pressure on the shoulder.

Fractures of the forearm that are septic can be treated by either of the methods just described by simply re-arranging the lines of pull to extend the forearm instead of the arm. If the wounds of the soft parts are very extensive I found a good method was to use a splint one can easily make and which we called a suspension extension tray. This consists of a zinc tray from one corner of which a drainage pipe runs, and with an upturned edge all round except in front. It has a wooden upright against which the upper arm rests for a counter extension, and the wooden attachment runs forward under the tray and has a pulley at its front end. Extension is obtained by glueing a cotton glove on the hand and running strings from the tips of the fingers to a piece of wood the width of the hand. From this piece of wood a cord runs over the pulley to the necessary weight. The whole tray, of course, is suspended on pulleys from an overhead bar.

For fractures of the carpus and metacarpus if the wound is not too extensive some form of ball splint is very useful. This consists of a straight wooden forearm splint with a tennis ball or wooden ball fixed to the end. This ball fits into the palm and maintains the double arch of the palm, which is so important. A similar splint serves for most fractured phalanges, with the addition of a piece of metal running forward from under the splint and having an upturned end distal to the tip of the injured finger. A glove finger is glued to the phalanx distal to the break and a string from its tip to the upturned bar secures extension. If either of the two terminal phalanges are fractured the best way to get extension is to bore a hole through the free end of the finger nail and to thread a salmon gut through to pull with. This method is quite painless and very efficient.

All these methods require arrangements for suspending splints, and I do not think it is possible to treat compound fractures with comfort and efficiency without it. It is not difficult or costly to erect, requiring merely two wooden bars on uprights running at right angles to the beds and over the head and the foot of the beds respectively. A notched lath can be placed across these two bars in any position and pulleys screwed into it. For suspending the splints, bags containing either sand or shot are convenient and can be weighted easily as required. I have only been able to give you a sketch of the types of splinting that have proved useful, but the great thing is not to have any fixed ideas, but to decide first what pull is needed and in which directions, and then, with the suspending apparatus in position, it is quite easy to work out the best type of fixation to secure what is desired and to fit it up. Even with no fixed suspending apparatus you will find that with three pieces of 2 by $\frac{1}{2}$ inch wood, each 6 feet long, you can do a good deal, fixing one bar at the head and one at the foot of the bed, and lashing the third from one to the other as a cross-bar, and if you do that, and use suspension, the additional comfort of the patient will well repay the time and trouble spent.

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Stamboul.

II.

Passing on we reach the city walls, that vast stretch of masonry which crosses the base of the triangle upon which Stamboul is built, from the Sea of Marmora to the Golden Horn. In a city so ancient their age seems scarcely of moment. The wreckage of an earthquake sixteen hundred years ago is still apparent, a marble gate built in honour of the almost legendary Theodosius still stands, the gleaming marble hardly touched by time. For nearly five miles, winding over hills and valleys, the great wall proceeds, its outer side deepened here and there by a great ditch, half filled with crumbling masonry. Built originally by the son of the great Theodosius in preparation for "the impending desperate struggle with barbarism," the story of the encounters that have been fought beneath its grim scarred walls would fill a volume.

As we reach the archway of the Edirneh Kapon, or gate of Adrianople, through which Muhammed II., the son of the prophet, passed in to the conquered city, and through which every succeeding Sultan must enter after the ceremony of his coronation at the Mosque of Eyoub, our way is barred by a long string of camels, sullen and dusty, who have come thus from Adrianople. We turn aside to glance at the mosque of Mihrimah, daughter of the mighty Suleiman, an unsightly mass of whitened masonry. From within rises a loud clamour, and, pushing aside the leather curtains covering the doorway, we see a merry scene of playing children, for the housing problem is so great owing to the refugees who have flocked to the city that the authorities have been forced to grant permission for the mosques to be used as dwelling places. Around the walls, screened off by old carpets, rush mats, or tattered curtains, countless families have made their *caravansirai*; the old priest, seeing us, beckons us in, but for olfactory reasons we hurry away. Passing through the gateway, where the Turkish soldiery eye us askance—we are far from the beaten track of the invader—and crossing the moat, here some twenty feet in depth, by a rackety wooden bridge, a prospect of rare beauty opens before us. Upon the bare slopes that stretch down towards the Golden Horn, a gipsy camp has settled, their scraggy goats and ponies browsing hungrily among the stone strewn herbage, while ragged children, differing absolutely in type from the Moslem, play listlessly amid the mud and filth. They are, perhaps, the kin of that curious race that inhabit the quarter between the Cannon Gate and that by which we have just left—the *Chinghench Mahalleh* or Gipsy Quarter—a maze of decaying barracks which the wary do not lightly enter.

Away beyond the little clump of trees that marks a graveyard, there lies the suburb of Eyoub, the sacred spot where no infidel might own a rood of land, and into whose mosque none but the faithful might enter, since it is the crowning place of all the Sultans, and the burial ground of not a few. On the heights above the dome and minarets, almost as far as the eye can reach, are little splashes of white, thousands, tens of thousands, rising to where the skyline is broken by the dark of cypress groves, down to the water's edge—the Sweet Waters of Europe—the scene in happier days of Turkish festival. They are graves, those of the twice blessed, for none may lie within the precincts of Eyoub who have not cast their eyes on Mecca, and to be buried thus within sight of the Mosque founded by the son of the prophet himself, carries with it the highest delights of Paradise.

There is always a strange ethereal beauty in a Turkish burial ground. Years ago—but the memory of it as I look across at these specks of white come back clear and vivid—I had seen my first graveyard on the desolate outskirts of a typhus stricken town in old Serbia. Against an angry winter sky these fantastic monuments reared up in profile, leaning forward, to right, to left, like fungi born from another world, dismal, altogether weird; then the tinkling of a little bell, and the voice of a priest from a minaret near by calling the *muezzin* in a place where all were dead or sick to death, and behind it all the snowclad mountain slopes, remote and menacing. Uskub and Eyoub—a far cry between—five years and many miles, and yet by some harmony of contrast the other comes and I must banish it almost by an effort as I stand at gaze here in the radiant sunlight. There is, in truth, little that is dismal in these acres of bygone mortality. One would almost think death a joyous thing to watch the decorous parties that on Fridays and holidays go out to picnic among the tombs. The napkin spread, the *dolmar* and the honeyed cakes, the rich carmine of the *pasteh* (watermelon), gracing the lichen covered slabs; the *pasha* dressed like a Parisian dandy, save for the scarlet fez, seated among his ladies, clad soberly in silk of blue or grey. The children shout and scuffle at hide and seek among the stones, peasant women lay down their earthen water pots and glance beneath the lowered *yashmak* at the lounging soldiery—the city of tombs is in this mellow summer season a haunt almost of gaiety. For the Turk does not, as we Westerners do, shut out his dead from all communion with the living. Every spot of earth not built on has its little group of tombs. Some are old and battered, so that the spidery characters seem to have lost all form of recognition, some so fresh that the colour upon the fez that marks the quality of its owner looks

to be of yesterday, and the paint and gilding on the flowers and fruit that signify fecundity strikes a note that is garish amid the surrounding decay. Many, like the tomb of poor Aziyadé, which we are to seek, lost and uncared for, have fallen—for the conventional form of the stone is top heavy, and inevitably sinks to one side—and perhaps have been used, simply and without irreverence, as walls or paving stones.

At our feet, as we look along the winding contour of the wall across to Pera, lie the waters of the Golden Horn, bordered and in some places almost covered by a forest of masts and rigging, the caïques that ply among the islands of the Sea of Marmora and mount painfully the current of the Bosphorus. Upon the slopes directly opposite is built the quarter of the Spanish Jews, a colony established in the days of Ferdinand and Isabella, and still speaking among themselves a bastard medieval Spanish. Farther down, past the rotting warships of the Turkish Navy, is Galata, the land granted to settlers from Galatia, and now the centre of the city's seafaring population. Near at hand, upon our own side, rises the Phanar, the cathedral of the Phanariote Greeks, who a century ago wielded such power that the security of the Empire was well-nigh shaken when they rose against it. For Constantinople is no city, but a medley of races and tongues, so that the traveller from Thibet or London (England) can find there his compatriots and his "quarter," and, having found them, can, if he be so minded, shut his eyes to all the rest.

It is only in Stamboul that one feels to be in the heart of a great city, august and stately, albeit fallen upon an evil chance, and can catch faintly the pulsing of a nation's life. The rest, a pell mell of Greeks, Armenians, Jews, the refuse of Europe and the East, polyglot and incoherent, with their *salons à la Franc,* their abominable *patois,* their affections (*ce sont les fourrures blanches et le linge sale,* as a French colonel tersely phrased it), stand for nothing, and inspire nothing but disgust and repulsion. Stamboul, for all its electric trams, telephones and postal system, is frankly Oriental, and since she seeks to be none other than she is, scorning the fripperies of the West, one must needs respect her.

Turning regretfully from the Golden Horn, we followed the dusty carriage track skirting the wall, that behind and before confronts us with its endless similarity, its towers and ragged battlements seeming like the ramparts of the city of a dream. As we near the Silivrian Gate, the slopes around become more thickly dotted with burial stones, the herbage more sparse, broken only by clumps of mournful cypress trees. Eagerly now, for we are nearing the great castle of the Seven Towers, we search the groups of tombs, hoping, altogether vainly, that among them we may find the little slab that marks the bed of Aziyadé. "Three or four women's tombs, painted in blue or green, with inscriptions and a wreath of strange flowers, about a dozen of them, upon a little hill," quotes my companion, for that and the date—1297 of the Hegira (for the Moslem calendar dates from the birth of Muhammed)—is our only guide. But, amid this population of the dead, to search for a single stone is wellnigh useless, and the summer's afternoon is drawing to a close as reluctantly we admit that we are baffled. After all, what does it matter? Our little pilgrimage, if it has done nothing else, has brought us a little nearer to the life of this strange city, a little nearer to the heart of that young naval officer who in after years came back to this spot to mourn.

The Marble Gate and the towers of Yedi-Koulé lie before us; soon we shall be hurrying past the slums of Psammatia, where the shores of Marmora meet the battlements, back to the quays of Galata, and the crowds that surge endlessly to and fro upon the mighty bridge, back to civilization and squalour. . . .

A little band of wayfarers comes out from the gates and pass joyously along the road towards the sacred fountain of Balukli, for whose reputed virtues Palælogus and after him a line of Greek emperors made yearly visits upon Ascension Day. The setting sun casts long shadows upon the battlements, the cypress, and the tombs. . . . The whistle of a train at the station, and we hurry through the archway—the Twentieth Century hath us in thrall.

G.H.F.G.

Appointments.

C. C. A. de Villiers, B.A., B.Sc., M.B., B.S., Tuberculosis Officer, Kent County.

Capt. H. F. Stephens, R.A.M.C., has been appointed Mental Specialist to the Northern Command in India.

C. E. M. Jones, Assistant Medical Officer, Lord Mayor Treloar Cripples Hospital.

Honours.

KNIGHTHOOD.

Alderman Sidney Robert Alexander, M.D., J.P., C.C. (Mayor of Faversham), in recognition of his public and municipal services.

Guy's Hospital Clubs' Union.

At a meeting of the Clubs' Union Council held on Friday, June 18th, it was proposed that, in view of the increased demands of the Students' Club and all the other Constituent Institutions and of the necessity for new expenditures at Honor Oak Park, the membership subscription be raised from three guineas to five guineas per annum. Before such a proposal can come up for further discussion and ratification it is required by Rule 23 of the Clubs' Union that at least fourteen days' notice be given to the Secretary of each Constituent Institution, and that notice also be posted in the rooms of the Students' Club and inserted in the GAZETTE.

A little consideration will soon show that this suggested increase is not undesirable. The grants made to the Constituent Institutions are of necessity on a far higher scale than in pre-war days, but in addition to that the Field Current expenses, the cost of upkeep of premises, and of the Ground at Honor Oak Park have been much increased. Furthermore, there is a prospect of large expenditures in the next few years on such desirable improvements as the hard-tennis courts now in course of construction, on extensions and improvements to the Stand and Pavilion, and, in view of the greatly increased membership, possibly even on new acreage for playing-fields. A new Constituent Institution has been added to the list, and a Ground will have to be rented for the Hockey Club during the coming winter. Most urgent of all is the question of the Students' Club premises, and the need for increased accommodation and comfort for its members.

The invested reserve of Clubs' Union funds has already to be drawn upon, and it is clear that, with the subscription rate as it stands at present, there must be a deficit in the coming year, notwithstanding the very considerable influx of new members. 387 new students have entered during the past year, as compared with an average of 123 for the three years preceding the war; but the rate of entry since the war is, of course, abnormal.

The grants to Constituent Institution for the three years preceding the war averaged £435 6s. 10d., and in the present year they amounted to £862 5s. 0d.

The Field Current expenses averaged £458 for the three years preceding the war, and in the present year they amount to £613.

The Constituent Institutions of the Clubs' Union are :—

The Association Football Club.
Athletic Club.
Cricket Club.
Debating Society.
Dental Society.
Gazette.
Golf Society.
Hockey Club.
Lawn Tennis Club.
Pavy Gymnasium Club.
Physical Society.
Rifle Association.
Rugby Football Club.
Rowing Club.
Students' Club.
Swimming Club.

and such other Institutions as shall subsequently be admitted.

Few of the other Hospitals possess so flourishing a Clubs' Union Organisation as Guy's. The Clubs' Union has weathered the difficult period of the war, and has also been able to steer through the financial stress of the first year of reconstruction. It remains only for its members to share with one another the present increase in the financial burden in order that the Union may start on a new period of prosperity and of utility to present, past, and future Guy's men.

The meeting of the Clubs' Union Council for further discussion on the proposed increased will be held on a date not later than July 31st, 1920.

Change of Address.

G. F. H. Bloom, 17, Welbeck Street, Cavendish Square, W.1.

C. G. Coombs, c/o Dr. C. Cooper, Poste Restante, G.P.O., Pietermaritzburg, Natal.

Capt. G. D. Gripper, R.A.M.C., attached 2nd Durham Light Infantry, Black Sea.

John H. Jones, M.R.C.S., Ministry of Pensions Hospital, Knotty Ash, Liverpool.

J. W. Mayer, M.C., 34, Ewell Road, Surbiton.

Lawrie McGavin. Phone No. is now Mayfair 2340.

Graham Poock, B.A., L.D.S., Seccondee, Gold Coast, West Africa.

Richard P. Rowlands, 10, Welbeck Street, W.1.

Capt. H. F. Stephens, R.A.M.C., Punjab Club, Lahore, India.

Ernest R. Stone, M.B., B.A., 7, Magdalen Road, Norwich.

W. W. Wingate, B.A., M.B., B.C., Cromwell House, Trumpington, Cambridge.

CORRECTION.

Dr. Poulton's address should read 15, Cavendish Place, W.1. (not Cavendish Square), Phone Mayfair 1460.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—I hold no brief for the Government; but surely your criticisms in "Passim" on the subject of grants are somewhat ill-informed.

On enquiry you might find that State aid, considerable if not adequate, had been definitely refused by certain institutions. The reasons are fairly obvious to any student of human nature.—I am, Sir, Your obedient servant,

June 29, 1920. X.

[Our correspondent admits that the State aid offered was inadequate. University College were willing enough to accept the Rockfeller gift; the refusal of other Institutions to accept State aid, "for reasons which are fairly obvious to any student of human nature," is in itself a sufficient criticism of the grants in question.—ED.]

United Hospital Rifle Club.

The first prize meeting since 1914 was held at Bisley on June 30th. The light and wind were constantly changing, so the scores were not good.

200 yards.—Wilmshurst (Thos.), 45; Bingay (Guy's), 42.

500 yards.—Beamish (Guy's), 45; Elgood (Bart's.), 43.

600 yards.—Mellows (Bart's.), 40; Elkington (Guy's), 38.

1,000 yards.—McVicker (Thos.), 24; Bingay (Guy's), 23.

300 yards Snapshooting.—Elgood (Bart's.), 20; Jory (Bart's.), 20.

300 yards Rapid.—Widgery (Guy's), 20; Lloyd (Guy's), 15.

Mappin and Webb's Prize.—Beamish (Guy's), 120; 2nd, Bennett (Bart's.), 116.

Grand Aggregate.—Elgood (Bart's.), 157; 2nd, Jory (Bart's.), 149.

The Armitage Cup was won by Guy's, 1,834 points; Bart's. were second with 1,796 points.

Professor Thompson, F.R.C.S., presented the prizes outside the North London Hut.

The scores of the Guy's team in the last shoot for the Armitage Cup were:

	200 yds.	500 yds.		Total
Beamish	41	45	=	86
Eksteen	36	41	=	77
Foy	35	43	=	78
Bingay	42	40	=	82
Lloyd	40	32	=	72
Elkington	36	35	=	71
			Total	466

Bart's., 449; London and St. Thomas's, 395.

In the Guy's Competitions Beamish won the Newton-Pitt Cup; Eksteen was second.

Handicap Competition.—Foy, 114; Eksteen, 112.

Vice-Presidents' Prizes.—Bingay, 146; Foy, 137.

Donegall Badge won by G. W. Elkington.

We are indebted to Messrs. Down Bros., Mappin and Webb, Holborn Surgical Instrument Co., Allen and Hanbury's, and especially the Vice-Presidents, for contributing to the success of the meeting by kindly presenting some of the prizes.

C. L. STEYN in the 440 yards (Inter-Hospital Sports).

Association Football Club.

REPORT OF GENERAL MEETING.

The general meeting of the Association Football Club was held on June 28th, 1920, the President (Dr. John Fawcett) being in the chair.

After the confirmation of the minutes of the previous meeting, the Hon. Secretary proceeded to read the season's report. He laid emphasis on the difficulties facing the club at the commencement of the season, and showed with what excellent results the period of reconstruction had been passed through.

The report having been adopted, Dr. Fawcett was unanimously re-elected President. He congratulated the club about their successes, and assured them of his support at all times. The meeting then elected the following as officials for the coming season:—

Captain:—D. H. Couch.

Vice-Captain:—D. J. O'Meara.

Hon. Secretary:—W. S. Brittan.

Asst. Hon. Secretary:—J. C. Hewetson.

Committee:—Messrs. G. P. Lindsay, M. Mackeith, R. Pengelly, R. van Geuns, and L. A. S. Trott.

The Committee would like to remind all "Soccer" men at Guy's that it is essential that they should place their services at the disposal of the club, as a united effort must be made to retain the cups next season.

Reviews.

A Manual of Midwifery. By T. W. Eden (Messrs. Churchill) price 24s.

The fifth edition of this well-known textbook differs but slightly from the fourth edition. The sections on the management of labour and on the newly born infant have been revised and enlarged. The high standard of the previous editions has been maintained.

Swanzy's Handbook of the Diseases of the Eye and their Treatment. Edited by Louis Werner, M.B., F.R.C.S.I. (Messrs. Lewis and Co.) price 22s. 6d.

The fact that a twelfth edition of this textbook has been published is sufficient testimony of its general appreciation by the medical profession. In the present edition, the chapter on Diseases of the Cornea has been re-classified and a brief account of superficial Linear Keratitis added. The practical details of treatment are very clearly stated and explained. We can confidently recommend this book to students and to practitioners who are interested in Ophthalmology.

Diseases of the Nose and Throat. By Herbert Tilley (Messrs. H. K. Lewis and Co.) 4th edition, price 25s.

The author has considerably enlarged this edition of his work in order to bring it thoroughly up to date. Not only have new chapters been introduced but old ones have been rewritten. The book is pre-eminently a clinical manual, pathological descriptions being short in comparison with the full accounts of symptoms, diagnosis and treatment. The illustrations are numerous, and have been reproduced with the utmost skill. There is also a useful list of prescriptions to be found in the appendix.

Guy's Hospital Hockey Club.

At a general meeting of the Guy's Hospital Hockey Club, held on June 28th, 1920, the following officers were elected for the 1920-21 season:—

President:—F. J. Steward, M.S., F.R.C.S.

Vice-Presidents:—C. H. Fagge, M.S., F.R.C.S.; A. W. Ormond, M.S., F.R.C.S.; E. C. Hughes, M.S., F.R.C.S.; L. Bromley, M.Ch., F.R.C.S.

Captain:—B. M. Tonkin.

Vice-Captain:—G. W. Owen.

Hon. Secretary and Treasurer:—J. R. A. Moone.

Committee:—J. W. Schollun, C. G. Bowen, J. E. H. Duckworth, B. C. Eglington.

Cricket.

GUY'S v. BICKLEY PARK.

Played at Bickley on Wednesday, June 23rd. The Hospital on winning the toss batted first, and fared very badly, 7 wickets falling for 74. At this stage Harris joined Muir-Smith, who had been batting admirably, and together added 67 for the seventh wicket. Muir-Smith, who was last out, played excellent cricket, giving only one possible chance. His innings saved the side from an absolute collapse. The ninth wicket added 52 runs.

Bickley, thanks to a fine innings of 132 by G. L. Crowe, who, however, was badly missed by Shearar quite early on, passed our total for the loss of four wickets. Crowe treated us to some fine hitting, his innings containing no less that two sixes and 21 fours. Scores:—

Guy's.

E. H. Muir-Smith, b Towle	105
B. B. Helder, b Towle	12
R. F. H. Duncan, b Towle	6
G. L. Shearar, c Jeffrey b Forbes	0
J. Van Schalkwijk, b Forbes	0
J. C. Hewetson, b Towle	0
W. H. Willis, st Platt b Forbes	4
J. C. Fauré, st Platt b Forbes	9
H. A. H. Harris, c Towle b Forbes	25
J. D. S. Thomas, c and b Forbes	9
T. J. Williams, not out	18
Extras	19
Total	207

Bickley Park.

G. L. Crowe, c Fauré b Hewetson	132
C. R. Douglas, b Schalkwijk	0
S. Platt, c Helder b Schalkwijk	44
T. L. Mansergh, b Schalkwijk	1
B. H. Tucker, b Fauré	0
F. S. Towle, c Willis b Hewetson	37
A. W. Forbes, b Schalkwijk	28
P. Simmonds, st Willis b Hewetson	4
R. F. Jenyns, c and b Hewetson	2
G. A. Jeffrey, not out	5
L. G. Jackson, c Duncan b Schalkwijk ...	4
Extras	13
Total	270

GUY'S v. BEDDINGTON.

Played at Honor Oak Park on Saturday, June 26th. The outstanding feature of this game was the fielding of both sides, especially Guy's. Some fine catches were effected. Biddle bowled well, his figures being three for 16. Scores:—

Beddington.

H. T. Tovey, b Biddle	9
H. D. Hayter, c Shaw b Biddle	3
T. R. Hammond, lbw b Biddle	5
T. O'P. Harrison, c Shaw b Schalkwijk ...	8
A. G. Dewar, c Helder b Wooldrige	12
J. C. Christie, c Hewetson b Wooldridge ...	29
G. Windsor, c Fauré b Wooldridge	0
T. P. Rothwell, c Wooldridge b Muir-Smith ...	10
H. Hayter, st Willis b Muir-Smith	7
D. Hayter, run out	0
F. C. Potter Irwen, not out	2
Extras	8
Total	93

Guy's.

G. D. Shaw, c H. Hayter b Rothwell ...	37
E. H. Muir-Smith, c Dewar b Harrison ...	28
T. Wooldridge, c Rothwell b Harrison ...	32
L. B. Helder, c H. D. Hayter b Dewar ...	0

P. B. Skeels, c H. Hayter b Dewar	2
F. J. Biddle, b Rothwell	1
J. Van Schalkwijk, c Rothwell b Dewar ...	2
W. H. Willis, b Harrison	21
J. C. Fauré, run out	7
J. C. Hewetson, b Harrison	14
G. L. Shearar, not out	4
Extras	19
Total	167

SEMI-FINAL INTER-HOSPITAL CUP.

GUY'S v. MIDDLESEX.

Played at Honor Oak Park on Wednesday, June 30th. Middlesex proved themselves the better side and won handsomely by 176 runs. The Hospital fielding before lunch left much to be desired, no less than four catches following hard on one another in the early stages of the game were missed, and this cost us dearly. Brice-Smith's 123 was an excellent innings, and W. H. Willis's dismissal of Gunesekara was a masterpiece of stumping. The Hospital had a difficult task before them when their innings commenced, and against good bowling did not do so badly to total 199. Muir-Smith and Schalkwijk played useful innings. The running out of L. C. Willis, who was batting well, and Shearar at a time when wickets were so precious can only be described as acts of absolute foolishness—the former should never have been called for a run and the latter in attempting a 5th run was well thrown out. Scores:—

Middlesex.

W. R. Ransom, b Schalkwijk	4
H. F. Brice-Smith, c Muir-Smith, b Schalkwijk	123
W. R. Van Langenberg, lbw b Skeels	46
C. H. Gunesekara, st Willis b Biddle	31
G. W. Karunaratna, c and b Schalkwijk ...	45
R. V. Hudson, c Wooldridge b Schalkwijk ...	49
R. L. Close, b Biddle	2
S. Somasunclarun, not out	43
J. Van Pike, c Willis b Wooldridge	0
E. Van Dyck, b Wooldridge	7
F. B. Yonge, b Wooldridge	0
Extras	25
Total	375

Guy's.

G. D. Shaw, b Van Dyck	2
E. H. Muir-Smith, b Gunesekara	46
T. Wooldridge, b Karunaratna	16
L. B. Helder, b Gunesekara	7
J. Van Schalkwijk, c Karunaratna b Langenberg	47
L. C. Willis, run out	24
W. H. Willis, b Van Dyck	15
G. L. Shearar, run out	17
J. C. Hewetson, b Gunesekara	11
F. J. Biddle, b Van Dyck	5
P. B. Skeels, not out	0
Extras	9
Total	199

GUY'S v. "CUACO."

Played at Honor Oak Park on Saturday, July 3rd. CUACO batted first and totalled 128. Schalkwijk bowled very well, his figures being four for 17. Guy's replied with 176. Wooldridge, who we are pleased to see is finding his form again, played very well for his score of 62. Scores:—

"CUACO."

—. Biggs, b Biddle	3
H. Weaver, c Biddle b Schalkwijk	14
L. Parnell, c Schalkwijk b Biddle	0
A. Rammell, b Schalkwijk	4
C. Grant, st Willis b Wooldridge	31
J. Butterworth, c Hewetson b Wooldridge ...	6
S. Beaumont, b Wooldridge	0
F. Milbourne, not out	30
G. Lomax, b Schalkwijk	1
R. S. Nightingale, c Wooldridge b Schalkwijk	19
J. Butterfield, run out	0
Extras	20
Total	128

Guy's.

L. C. Willis, b Milbourne	10
E. H. Muir-Smith, c Rammell b Weaver ...	19
T. Wooldridge, c Grant b Milbourne	62
G. D. Shaw, b Milbourne	7
L. B. Helder, b Beaumont	15
J. Van Schalkwijk, c Parnell b Beaumont ...	2
G. L. Shearar, b Milbourne	22
J. C. Hewetson, b Weaver	3
L. Weinberg, b Milbourne	16
V. R. Estment, not out	3
F. J. Biddle, c Parnell b Milbourne	0
Extras	17
Total	176

Specialities.

The Antiseptic "Iglodine," which is a triad salt of Iodine with the formula $C_4H_7I_3 + H_2O$ has been prepared by the Iglodine Co., Limited, in three forms, viz.:—

Iglodine Antiseptic (Standard),
Iglodine concentrated aqueous, and
Iglodine embrocation.

It may be classed amongst the most efficient antiseptics on the market, as its germicidal value has been established by a prominent bacteriological expert.

It also acts as a sedative, and may be further recommended for its healing properties in the case of wounds, etc.

The Iglodine Co., Ltd., will be pleased to forward samples to medical men on application.

Death.

HIND.—On the 21st June, Lieut.-Col. Wheelston Hind, T.D., M.D., F.R.C.S., F.G.S., third son of the late W. M. Hind, formerly Rector of Horningtон, Suffolk.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT was with considerable interest that we heard of the alterations that are to be introduced into the present scheme of instruction in Obstetrics, Gynæcology, and Diseases of Children at this Hospital. Under the old system—as everyone knows—the student having done the ordinary work in general medicine and surgery for fifteen months, then proceeded to do a three months' appointment of dresser in the midwifery and obstetric wards; one month of the three, however, was devoted to extern work on the District. Following on this, the student then undertook another compulsory appointment, spending half his time clerking to the Physician-in-charge of the Children's Department and the rest of it in clerking to the Neurologist or Dermatologist.

Under the *new* scheme, he will do three months' dressing in Victoria and Queen wards, and during the time he will clerk to the Children's Physician once a week. After this he will do a second three months' appointment, spending one month on the District and the rest of the time in studying the child in health and disease.

Several advantages result from the new scheme. Firstly, the student devotes almost the whole of three months to learning practical and theoretical midwifery and gynæcology instead of spending a large part of his valuable time on the District, or on recovering from the effects of his activities there.

Secondly, the student will now no longer work with a rule-of-thumb knowledge of the management of the various stages of labour and in complete and pitiful ignorance of the answers to all those numerous questions, that both mother and midwife are in the habit of asking the extern in charge of a case.

An extern with no previous experience could not be expected, for example, to recognise the presence of a few ephemeral scratchy râles in the chest of an infant, much less to appreciate their full significance. We may, however, expect that the extern of the future with some general knowledge of child-craft, will be able to apply this knowledge to some real purpose instead of invariably prescribing Pulv. Hyd. cum Cræta, as a panacea for all the ills of infant life.

Lastly, even more time will be devoted to the study of pediatrics than has been the case in the past, for the teaching of it will, we hope, be unassociated with instruction in any other of the so-called special subjects.

But with all the numerous apparent advantages that the new scheme affords, no real benefit can result from it, unless an effort is

made to ensure that every student shall, in the future, have opportunities of obtaining practical experience of such manipulations as forceps application and versions.

At present all that the obstetric dresser learns about practical midwifery is gained in the conduction of twenty or more normal labours; the rest of the work he learns out of a book, or by watching the Charity perform the numerous special operations of obstetric practice.

ff this state of affairs is to continue, there seems to be no point in the student spending an extra month in the midwifery and gynæcological wards, when the additional knowledge that he gains thereby could be obtained equally well by reading a text-book in his study.

Unfortunately, Victoria ward is very small, and the other Departments have such long waiting lists, that it is probably impossible at present to devote additional beds to lying-in patients. Herein lies the great defect in the new scheme; and until this is remedied the obstetric dresser of the future will, we think, be little better off than he was in the past.

WE wish to congratulate Professor T. Martin Lowry, who has just been appointed to the newly-instituted chair of Physical Chemistry at Cambridge University. Both as a teacher and as a research worker, Dr. Lowry is well known. It is in his capacity as teacher that he has been of especial service to us at Guy's. For his valuable research, he has gained many distinctions: recently he received the Italian Order of St. Maurice and St. Lazarus, while in March last he was made a Commander of the Order of the British Empire.

Though, of course, we are pleased to think that Dr. Lowry has been appointed to this important academic post, our pleasure is leavened by the knowledge that Guy's will be deprived so soon of a distinguished scientist and an inspiring teacher.

IN the sporting columns on another page will be found a letter notifying the discovery of a number of Challenge Cups and other trophies which were won by the Guy's Boat Club over half a century ago. We suppose that few of the original Boat Club's supporters are now alive, but there may be, perhaps, some old Guy's men who were interested in the Club, or who know something about historical records or reminiscences relating to its past career. Should this be so, any communications on the subject would be read with great interest by everyone, but more especially by the members of the new rowing club which is now in the process of formation.

We print elsewhere a notice embodying an appeal to those men who are at all interested in rowing, to join the Boat Club at once. We wish to give special prominence to this appeal, for it is only by taking advantage of all the ability and enthusiasm at our disposal that we can hope to emulate the triumphs of the past.

IN the last number of the GAZETTE we recorded the death of Lt.-Col. Wheelton Hind, who qualified from Guy's in 1882, and later took the F.R.C.S. and M.D. Lond, winning two gold medals.

Men of his time will remember his great ability, which is shown by the fact that he was not only a busy operating surgeon working at the Stoke-on-Trent Hospital, and carrying on at the same time a large private practice, but he was, in addition, a famous geologist, the author of many original papers, for which he was awarded the high honour of the Lyell Medal in 1917.

But apart from all these activities, Lt.-Col. Hind was an ardent Territorial Officer, and went out to France as a combatant with his battery at the outbreak of war.

Some Mechanical Considerations in the Surgery of the Leg.

CLINICAL LECTURE BY W. H. TRETHOWAN.

GENTLEMEN,—In your preliminary studies, before entering upon clinical work in the wards, a sharp distinction is made between the two subjects of anatomy and physiology,—between the structure of the body and the use to which that structure is put. You are accustomed to think of anatomy and physiology as two quite distinct subjects, and I could wish that, in your clinical work, you would have as clearly in mind the two separate aspects of the treatment of any surgical condition. Your treatment does not finish when you have restored a damaged structure as completely as you can, for there remains the even more important necessity for restoring the complete use of the damaged part. It is, perhaps, in the Orthopædic Department where we are particularly concerned with the restoration of function; and to guide you in the general principles of treatment, I am accustomed to emphasize the analysis of what disability really consists. From the results of the war, and the necessity for dealing with all sorts of types of disabled soldiers, the importance of the psychical aspect of disability has been brought very much to the fore. While much good has been done by insisting upon the patient's own efforts to fight against his disability, by re-education and training, and by the various suggestive methods, it is important to keep a sense of proportion, and to have clear in our own minds that disability in any particular case is frequently a combination of psychical and physical deficiency. A particular lesion of a bone or joint may reduce the efficiency of the leg, considered as a mere machine, by, say, 30 per cent. Should this lesion occur in a man of vigorous mental type who is able, or wishes, to help himself, we may have no psychical element of disability of any importance, and the man's total disability can be estimated at 30 per cent. In another case, with a precisely similar lesion, the patient may be unable or unwilling to fight against his own defect, and, from this psychical cause, his efficiency may be lowered, by, say, another 50 per cent. So it is important, therefore, in the treatment of any particular patient to estimate how much the treatment must be by physiotherapy, and how much by psychotherapy. These two are not distinct treatments, but go hand in hand. The physiotherapy cleans and tidies up the machine, and puts it into the best shape and attitude for doing its work; but the psychotherapy and re-education impart and augment the driving force.

From the purely physical aspect, disability is a question of deficiency of movement and power. In most cases of lesion of the leg, for example in all bone and joint diseases and injuries, it is movement that is of primary importance; and it is to the restoration of movement that we direct our first efforts. Muscular weakness and the deficiency of power will, of course, occur secondarily, but if we restore the movement, the power will, so to speak, be restored automatically. Therefore limb surgery resolves itself into an investigation why a joint is deficient in movement; whether the deficiency be due to causes without the joint or within it; and what is the normal movement of the joint, and how best we can restore it.

In other cases of disability, however, the prime defect is in the neuro-muscular apparatus; such cases are those due to the various paralyses. Here the joints are freely moveable —perhaps too moveable and uncontrolled—and as an uncontrolled joint is worse than no joint at all, we resort, during the period that the muscles are too weak for function, to artificial support of the joint by external splinting and appliances, or by some internal fixative operation. The structure of the limb is absolutely adapted to its function, and if there is any defect in its anatomical structure there must also be some corresponding defect in its utility. Therefore we presume that the exact reconstruction of a deformed limb or segment will give us the maximum return of usefulness. In

this lecture I am confining myself to methods of treatment for restoring the damaged structure, and will not now deal with the particular means for reviving the deficient function. I want to deal principally with the effect and treatment of mal-united fractures of the long bones of the leg.

Apart from those pathological processes occurring in the leg tissues which are similar to those elsewhere in the body, most of the surgery of the leg is merely a question of mechanics. We remember that the leg has two functions: the simpler and elementary one of standing—the attitude of rest; and the more complicated co-ordinated muscular or leverage action—the attitude of "activity." In the attitude of rest the strain falls on the ligaments, and muscle action is reduced to a minimum; the joints are locked in an extreme position of the range of movement, and the larger and more important ligaments are tense. This position is adapted to standing still, and not to walking; but when need arises the patient can walk after a fashion in this attitude. It is not, however, good, and leads to damage of the joint surfaces and ligaments. In the attitude of activity the ligaments are not tense, the joints not in extreme positions, and the control is by means of the muscles only. It is the attitude of readiness for quick action. Any injury, however seemingly trivial, is very liable to throw muscular activity out of gear, and make the patient only too readily resort to locomotion in the "rest" state; in other words, he stumps as if he had a wooden leg. For healthy function an alternation of these two attitudes is necessary. Muscles and ligaments take their periods of rest and activity alternately with each other. Ligaments perhaps require more rest than muscles; it is much easier to walk for an hour than to stand still for a like period. Muscular wasting and fatigue is more quickly restored than is the ache and slackness of the over-stretched ligaments. Consider the standing position, or passive attitude of rest. The hip and knee joints are hyper-extended, the strain falling on the ligament of Bigelow, and on the ligament of Winslow, the crucials, and the internal lateral ligament of the knee respectively. The legs are abducted, the feet somewhat everted, and the inner ligaments of the foot and ankle tense. The lumbar spine is lordosed and the chest thrown back. The line of body weight falls just behind the hip joint, through the fore and outer part of the knee joint, and through the inner side of the ankle joint towards the arch of the foot.

From its peculiar formation the skeleton of the leg is structurally weak, and the stress of weight bearing through a pillar which is not absolutely perpendicular is liable to lead to certain types of deformity, varying with the site of the lesion, in cases of delayed or non-union after a fracture. The production of similar deformities is also met with in cases where the bones are softened from disease, such as in rickets, and also in the big group known as the adolescent or static deformities. For example, in fractures or softening of the neck or the upper half of the shaft of the femur, as the line of weight falls within the femur, we are prone to get diminution of the angle of the neck, or coxa vara, and, in the case of the upper shaft, outward bowing or angulation. As in the region of the knee joint the line of weight tends to fall to the outer side and front of the joint, and on account of the natural over-extension of the knee, and, again, because of the natural valgus shape of the knee joint itself, we are liable, in conditions of the lower femur, the knee joint, and the tibia, to meet deformity in which the natural hyper-extension and inward projection of the knee is exaggerated. In other words, backward bowing or angulation of the lower half of the femur, or of the tibia, or at other times knock knee deformity, may result from the undue stress of weight bearing. In the lower half of the tibia and in the ankle region, the line of weight tends to pass again to the inner side, and, as it is also rather towards the front of the leg, we are liable to see angulation of the tibia either in an inward or backward direction. The tendency to shortening of the tendo Achillis from spasm or contracture of

the calf muscles is also liable to result in backward bowing of the lower half of the tibia, a factor which acts both when the patient is lying up, from a too right-angled position of the foot, and also when the patient gets about again and bears weight. Thus the natural incurving of the lower third of the tibia is lost, and the resulting abduction of the foot disturbs the normal horizontal level of the ankle joint and throws undue weight upon the inner part of the arch, or upon the heel, as the case may be. In the recumbent position, too, the weight of the limb has some influence in the production of deformity. For example, the eversion of the leg seen after fracture of the neck of the femur, or in coxa vara, results from the static rotation outwards which the weight of the limb causes; again, the backward sag of the limb is liable to cause the excessive recurvatum deformity which may follow fractures both of the femur and of the tibia.

Deformity resulting from the malunion of a fracture may occur in one or more planes, and the various types that are met with may be arranged in the following order of severity of disability: Fractures directly involving articular surfaces, with permanent displacement of fragments; angular union when associated with overlapping and rotation of the fragments; angulation with end to end apposition; rotation; and pure shortening. Now Wolff's law states that the internal and external configuration of a bone is adapted to the function it subserves. If from accident this configuration is disturbed permanently, the stresses on the bone are altered, and the bone makes some effort to change its shape and adapt itself to its new position and function. The bone is a materialisation of lines of force, and the adaptation is an attempt at re-crystallisation. The younger the patient the more favourable is the outlook for this beneficial adaptation. We see its effect in the tendency to continue upwards the line of the lower fragment in the case of an overlapping union; also in the buttressing or filling up of the concavity in an angular union. The bone ends, where they form the articular surfaces of the joints, are the sites where the altered stress has most effect. In the case of the knee and ankle joints we must remember that the joint line and the joint axis is normally quite horizontal, and that any mal-shape of the bone above or below throws out of bearing this horizontal position. In the case of the hip joint, the trouble is either that the bearing surface of the ball is altered relatively to the socket, or that a partial subluxation throws the weight stress on too small an area of the head of the femur. Articular cartilage will not stand a too local pressure or the effect of repeated trauma. Disturbance of the axis of rotation of the joint leads to uneven bearing on portions of the cartilage, and jamming and locking of some of the joint edges. In consequence the bruised and damaged cartilage is soon eroded and disappears, and its place taken by patches of granulation tissue, or by bare bone. Thus is brought about the condition known as traumatic or mechanical arthritis, which nothing can alleviate until the fair working of the joint is restored. The joint movements are restricted, and chronic stiffness, pain and creaking lead to permanent disability. Thus the evil effect of malunion falls primarily on the joint, and is worse the nearer the fracture is to the joint. The severity of the disability will, of course, depend on the adaptation of the bones and the joints to the new shape of the limb; it varies with individuals, but the adaptive power is always more marked in children than in adults. Remembering then that weight bearing is the most important factor in the production of deformity, we must take care that weight is not assumed too early, and before the bone is thoroughly consolidated. Often the good result following the treatment of a fracture is marred eventually by allowing the patient to take weight too soon, but we could always prevent this calamity by the use, for some months, of a supporting appliance.

The commonest malunited fractures we see in the Orthopædic Department are those result-

ing from various injuries in the region of the ankle joint, the cases being sent to us for treatment, as often suggested, "with a boot." I wish to show you some lantern slides illustrating these fractures. They have hitherto been known as the various degrees of Pott's fracture, and Dupuytren's fracture, but Sir Arbuthnot Lane's etiological classification into abduction and adduction fractures is of far more value for descriptive purposes. The commonest fractures in the region of the ankle joint are those due to a twisting in of the leg while the foot is held firmly on the ground; in other words, the foot is violently abducted or everted. Such an injury by indirect violence or torsion does not necessarily produce a fracture in the malleolar region, for the infraction plane may pass obliquely through the tibia and fibula at any level between the ankle and the knee. In all cases, however, the fibula breaks at a higher level than the tibia, and the result, when in the shaft of the tibia, is the production of an oblique or spiral fracture. Whether there occurs a malleolar fracture, such as one or other of the three degrees of abduction fracture, or whether the lower ends or shafts of the tibia and fibula are broken, is merely an accident. Generally speaking, of course, the malleolar fracture is the more serious, as the line of infraction passes through the ankle joint itself. The type of deformity which results is similar in all cases, but varies in the degree of severity. Thus in the simplest or first degree of abduction fracture at the ankle the external malleolus is twisted off, and with it the internal lateral ligament of the ankle joint is torn, or the internal malleolus snapped across; there is, however, no displacement. In the second degree of abduction fracture, the plane of fracture is as before, but the foot, together with both malleoli, is displaced outwards and rotated, or everted, and the fibula tends to be shortened by overlapping. The seriousness of this fracture lies in the fact that the astragalus is subluxated, its upper horizontal bearing surface displaced, and the body weight transmitted through the inferior tibio-fibular articulation to the outer astragaloid edge. In the third degree of abduction fracture the outward displacement of the foot together with the malleoli is more marked, but, in addition, the astragalus is completely displaced backwards from the articular surface of the tibia, carrying back with it a fragment from the outer corner or posterior margin of the lower end of the tibia. In abduction fractures of the shaft of the tibia and fibula, the condition is slightly less serious, in that the fracture does not involve the ankle joint itself; but the type of deformity which results resembles that occurring after the malleolar fractures. The lower fragments are displaced outwards with the foot, and rotated outwards, and shortening is liable to occur from the lower fragments driving upwards and behind the upper. Thus the incurving of the lower end of the tibia is lost, and weight falls less through the ankle joint and more towards the inner border of the foot. It will be seen that abduction fracture of the shaft has the same deleterious effect in disturbing the normal horizontal bearing surface of the ankle joint. Sometimes, as in a case I show you, the infraction of the tibia may not be complete, but is merely an L-shaped splitting, with the usual displacement outwards of the lower fragment. At other times we get a long or short oblique, spiral, or torsion fracture of the tibia. Injudicious attempts at keeping the foot at right angles while the leg is in splints may add a backward angulation element to that of the above described "valgus" or abduction deformity. Less commonly occurring fractures in the region of the ankle joint are Lane's first and second degrees of adduction, or "varus" type, classified according to whether there is no deformity or whether the foot is thrust and impacted into an adducted or inverted position. In the adduction fracture the cleavage of the external malleolus tends to be more transverse, while the internal malleolus is broken off at its base by the impact of the thrust from the astragalus. The deformity following the adduction fracture is much more easy to correct than that resulting from an

abduction break. The adduction fracture results from a thrust outwards of the leg while the foot is pinned to the ground by its external border. The adduction malleolar fracture has not its counterpart in similar fractures of the shafts of the tibia and fibula, as have the abduction fractures, except that to a certain extent it somewhat resembles the transverse and comminuted fractures of the shaft which result from direct violence.

The persistence of malunion of an abduction fracture will ruin the function of the ankle joint because of the persistent derangement of the joint bearing surfaces, and the consequent production of traumatic arthritis. As mentioned above, this deleterious effect will be more marked the nearer the line of fracture is to the joint, and reaches its maximum where the joint itself is involved, as in the malleolar fractures. In the malleolar fracture we must restore the bearing surface of the astragalus relative to that of the tibia, and also the horizontal position of the rotation axis. In abduction fractures of the shaft there is no relative displacement of the joint surfaces themselves, and we have merely to make the joint level. In the malleolar fractures, as Lane has insisted, the foot and ankle joint will fall into their natural positions if we accurately restore the contour and alignment of the fibula; the teaching that no effort should be spared to restore the fibula, by operation if necessary, and that as early as possible, is most important. The same indication will hold in old cases of persistent deformity, but here the problem is much more difficult. We have to deal with a fibula which has for some time been shortened by overlapping, with an internal malleolus which is displaced outwards, with tendons and other tissues on the outer side of the leg and foot which have become firmly contracted, and finally with a joint which is badly damaged by functioning in an improper position. The disability we have to meet is the stiff and painful foot on which walking to any extent is impossible. The little movement which exists in the ankle joint is very painful, and the lameness considerable. It is of no use to brand this condition as a "traumatic flat foot"—it is no such thing, nor can it be dealt with by building up the inner side of the sole and heel of the patient's boot. The addition of an outside steel extending to the knee and an inside T-strap will not assist matters very materially. The conventional treatment by trans- or juxta-malleolar osteotomy, with subsequent so-called correction in plaster, will not fulfil the essential condition of restoring the internal derangement of the ankle joint, and I have never seen sufficient benefit following this operation to make it worth while doing. No treatment can be of any avail which does not restore the original length and alignment of the fibula, and mere section of the fibula and retention by a metal plate is useless, both on account of the difficulty of overcoming the contracture of the soft parts and of fixing the atrophic lower fragments with screws. In neglected abduction fracture cases the best method of correcting the deformity of the foot and ankle joint will probably be found by dividing the fibula some four or five inches above the malleolus, lengthening it by displacing downwards the lower fragment to the desired degree by means of direct traction, and then filling the gap so formed by an autogenous bone graft taken from one or other tibia. Such a method we have tried, and it promises excellent results. If such reparative operation is unavailing or impossible, the only means of relief will be by a Syme's amputation. Progression on a Syme's stump is immeasurably superior to that on a stiff, painful and rigid foot.

(To be continued.)

Notice.

Applications are invited for the Arthur Durham Travelling Studentship of the value of £100. Copies of extracts from the Regulations governing the Studentship may be obtained at the Medical School Office.

Applications should be sent to the Dean, at the Medical School Office, on or before the 1st September.

Guy's Hospital,

16th July, 1920.

Herpes Zoster.

BY H. W. BARBER, M.D.

THE term "herpes," like "lichen," was formerly applied to a variety of very different eruptions; thus, apart from herpes simplex and herpes zoster, ringworm of the scalp was called "herpes tonsurans," pityriasis rosea of Gibert is the "herpes tonsurans maculosus of Hebra," "herpes gestationis" is probably a variety of dermatitis herpetiformis occurring in pregnant women, and "herpes excedens" is an old name for lupus vulgaris. At the present time by "herpes" is meant herpes zoster, or herpes simplex, either of the lips or genitals.

From herpes zoster, herpes simplex must be sharply differentiated, although the clinical and histological appearances of the actual skin lesions are much the same in the two conditions; the former is due to inflammatory or other changes in the posterior root ganglia, and very seldom occurs more than once in a lifetime; the latter is probably due to a toxic neuritis affecting the terminal filaments of a branch of a cutaneous nerve, and it is notoriously liable to recur repeatedly, both when it involves the lips and on the genitals.

The association of herpes zoster with disease of the posterior root ganglia was shown by Von Bärensprung as far back as 1862, and additional post-mortem evidence was later obtained by Charcot, Lesser, and Dubler. Moreover, in the seventies, Wyss and Saltler described cases of herpes ophthalmicus associated with hæmorrhage into the gasserian ganglion. But it is to Head and Campbell that we owe most of our knowledge of the pathology of the disease; they were able to examine post-mortem over twenty cases at intervals, varying from a few days to a year and a half, after the appearance of the eruption. In the acute early cases they found hæmorrhages and inflammation in the posterior root ganglia corresponding to the affected areas of skin, and in the later cases patches of sclerosis. They were also able to demonstrate secondary degeneration both in the peripheral afferent nerves and in the posterior spinal roots, the degenerated fibres being traceable for a considerable distance upwards in the posterior spinal columns. They found similar changes in the gasserian ganglion in three cases of herpes involving areas supplied by the trigeminal nerve.

Etiology.—It is thus clear that zoster is associated with changes in the posterior spinal root ganglia, or in the gasserian ganglion, which is morphologically their equivalent.

We have next to consider to what these changes are due. In a few cases the eruption is a symptom of some definite disease of the nervous system, and Dr. Head terms this "Symptomatic Zoster." Thus it may occur with spinal caries, one or more ganglia being involved in the inflammatory process, and Head and Campbell observed one case in which the ganglia were invaded by sarcoma. Zoster may complicate myelitis, and it is seen not uncommonly in tabes; in five cases of this disease observed by Head the herpetic eruption occupied the site in which violent lightning pains had been experienced. It must also be remembered that an attack of herpes may be the first symptom of involvement of the central nervous system in cases of syphilis, but the arsenical preparations used in the treatment of this disease may also predispose to an attack.

Apart from these instances of "symptomatic herpes," in the vast majority of cases Zoster is an acute disease, due undoubtedly to bacterial infection,, the causal organisms picking out one or more posterior root ganglia, or the gasserian ganglion. It is still doubtful what the organism is; possibly it is not the same in every case, *i.e.*, it may not be specific. Head and others have pointed out the similarity between an attack of herpes and one of acute poliomyelitis, and it has been suggested that both may be due to the same organism, the anterior horns being picked out in the one case and the posterior root ganglia in the other. Recently Le Feuvre and several other observers have collected cases to show that there may be a common origin for Zoster and chicken-pox, and it must be admitted that the evidence adduced is striking. Chicken-pox in one or more children of a family may follow an attack of shingles in a parent, or vice-versâ; Goldberg and Francis observed three cases of shingles and a simultaneous eruption of chicken-pox in three adults aged 27, 38, and 53 respectively, and Corlett has published four similar cases. Head himself describes the case of a boy who developed Zoster in the fifth dorsal region, and within twenty-four hours a typical eruption of chicken-pox. The association of the two diseases has now been vouched for by so many independent observers that it is difficult to ascribe it to mere co-incidence; personally, I

have failed to obtain any evidence of such an association, and, while ready to admit that the virus of chicken-pox may sometimes produce Zoster, I think that it must be an exceptional cause of the disease. Many of my adult patients with herpes have given a history of having had chicken-pox, so that the latter confers apparently no immunity against the former.

Rosenau and Oftedal have brought forward considerable evidence to show that in some cases, at any rate, the infecting organism is a streptococcus, which enters the blood-stream through diseased tonsils or gums, and which possesses an elective affinity for the posterior root ganglia. One case that I have had under my personal observation for some time supports this view. A lady was sent to me by a colleague, owing to a severe attack of right supra-orbital herpes zoster. For the previous two years she had had persistent and very painful neuralgia of the right side of the scalp, following a fall; during this period she had also a right-sided facial palsy. She suffered, too, from rheumatoid arthritis. It seemed likely to me that her arthritis, her neuralgia, her facial paralysis, and her attack of herpes were all due to infection from some focus. X-ray examination of her teeth did not suggest that these were the source, but her tonsils were found to contain considerable quantities of liquid pus. Owing to her age and general condition it was not considered advisable to enucleate the tonsils, but they were cleaned as far as possible with antiseptic applications, and cultures from the pus were taken, from which a practically pure growth of a streptococcus longus was obtained. A vaccine was prepared.

Following the manipulation of the tonsils, an acute attack of iritis in the right eye developed, but this subsided satisfactorily. Small doses of autogenous streptococcal vaccine were given, and following some of the injections *a slight recurrence of the supra-orbital herpes occurred*, accompanied by a temporary exacerbation of the joint pains. With the vaccine treatment the neuralgia of the scalp has practically disappeared.

There can be little doubt that in this case the infection of the tonsils was responsible for the arthritis and iritis, for the neuralgia and facial palsy by causing an infective neuritis of the trigeminal and facial nerves, and for the herpes ophthalmicus as a result of acute infection of the gasserian ganglion. The recurrence of the herpes after some of the injections of vaccine is a point of extreme interest.

Symptomatology.—A description of the eruption in herpes zoster is unnecessary here, but it may be noted that an attack is usually associated in the early stages with a rise of temperature and a feeling of malaise. I have been struck by the frequency with which a sore throat precedes the appearance of the rash.

An important and constant accompanying symptom is enlargement and extreme tenderness of the lymphatic glands in the neighbourhood of the eruption. This is not the result, as has been suggested, of secondary pyogenic infection of the herpetic vesicles, since the tenderness and enlargement of the glands usually, in my experience, occurs before the involvement of the skin. In one case I was able to predict an outbreak of Zoster owing to the distribution of a neuralgic pain, and the associated glandular enlargement.

Some observers have found a definite lymphocytosis of the cerebrospinal fluid in patients with herpes; in other cases the fluid has been quite normal. But lumbar puncture is hardly justifiable in a case of Zoster unless syphilis, tabes, or general paralysis of the insane be suspected.

Although more than one posterior root ganglion may be affected on one side in herpes of the trunk and limbs, *bilateral zoster* is extremely rare. Dr. Ryle and I have recently seen a case, however, in which the second and eighth dorsal root areas were involved on the right side, and the eighth dorsal on the left. A short time ago I published an account in the *Lancet* of a boy who had Zoster of the left side of the chest and of the ophthalmic division of fifth nerve on the same side simultaneously. As far as I know the case is absolutely unique, and Dr. Head tells me that he has never seen or heard of such a combination. The association of Zoster of the trunk or limbs and *catarrhal* herpes of the lips is quite common.

Occasionally an attack of Zoster is accompanied by motor paralysis. Thus facial paralysis may occur with herpes in the second cervical root area. Ramsay Hunt has shown that herpes of the auricle and external auditory meatus is not infrequently accompanied by facial paralysis, and he attributes it to inflam-

mation in the geniculate ganglion. Again, herpes ophthalmicus may be associated with complete ophthalmoplegia, externa and interna.

A short time ago I read of a case of Zoster of the chest in which a pleural rub was heard in the region of the eruption. Curiously enough the next case of dorsal herpes that I examined, after reading this, also had a definite pleural rub, but Dr. Head states that he has never noted the association.

Treatment.—The best treatment for the eruption is to cover the vesicles with a dusting powder containing boric acid, zinc oxide, and starch. Ointments and lotions are not so satisfactory as dry powder.

Except in elderly people the pain does not usually last long, and can be relieved, as a rule, with aspirin or pyramidon. In the aged, however, the agony may be intense, and may persist for months after the eruption has disappeared; it has, indeed, been known to lead to suicide.

Papers by Guy's Men.

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The Landon Out-Patient Tea Fund.

STATEMENT OF INCOME AND EXPENDITURE
for the year ended March 31st, 1920.

INCOME.

	£	s.	d.
To Donations and Collections	122	13	6
„ Interest on Invested Funds—			
5 per cent. Exchequer Bonds 7 0 0			
Deposit Interest 1 1 11			
	8	1	11
	£130	15	5

EXPENDITURE.

By Tea, Groceries, Provisions, Fruit, etc.	25	11	2
„ Toys, Gifts, etc.	46	10	9
„ Police Fees, Gratuities, etc.	7	0	0
„ Printing, Stationery, Postages, etc.	5	3	2
„ Fee for Band	8	8	0
	92	13	1
Excess of Income over Expenditure	38	2	4
	£130	15	5

BALANCE SHEET,
March 31, 1920.

LIABILITIES.

To Accumulated Funds—						
Balance brought forward from last account	263	5	2			
Plus Excess of Income over Expenditure for 12 months to March 31st, 1920	38	2	4			
				301	7	6
				£301	7	6

ASSETS.

By Investments—						
£200 5% Exchequer Bonds at cost				200	0	0
„ Cash at Bankers—						
On Deposit Account	100	0	0			
On Current Account	1	7	6			
				101	7	6
				£301	7	6

F. A. SHELDON,
Treasurer.

Audited and found correct,
W. J. CURRY.

Landon Tea Fund Committee,
Guy's Hospital Trained Nurses' Institution,
14, St. Thomas's Street, S.E.1.
May 4th, 1920.

Appointments.

Guy's Hospital Medical School.

CLINICAL APPOINTMENTS.

July 16th—October 15th, 1920.

Surgical Ward Clerks.—Messrs. C. H. Atkinson, S. C. Bakhle, H. L. Bernstein, V. R. de Boissiere, W. G. Booth, G. E. Fisher, A. W. Hall, M. Jackson, E. H. Koekner, J. T. Linklater, H. J. Plowright, F. R. Ratnagar, D. G. Robinson, G. M. Stoker, C. G. Taylor, and D. B. Whitlock.

Clerks to Medical Units (first three months).—Messrs. H. P. Baylis, H. T. Chiswell, R. Hale-White, W. G. R. Hore, F. D. Howitt, J. S. Hudson, C. Kark, L. H. B. MacLeod, C. A. Marais, C. C. Po, W. H. Ramsden, P. E. Sedgwick, D. G. Sharp, D. A. Windemer.

Dressers to Surgical Units (first three months).—(Sir A. Fripp and Mr. Turner) Messrs. H. K. Wallace and H. Richards; (Mr. Steward and Mr. Hughes) Messrs. B. L. Laver, F. W. Widgery, and H. A. H. Harris; (Mr. Fagge and Mr. Davies-Colley) Messrs. J. F. Payan, I. Bechal, and H. B. Flooks; (Mr. Rowlands and Mr. Bromley) Messrs. M. Mackenzie, E. R. Boland, and M. M. Hegab.

Clerks to Medical Units (second three months).—(Dr. Fawcett and Dr. Cameron) Messrs. H. B. Jones, A. H. Douthwaite, M. A. El-Biblawi, and A. Farid; (Dr. Beddard and Dr. Hunt) Messrs. D. Davies, J. N. Alexander, C. Shepherd, and A. R. V. Patel; (Dr. Hurst and Dr. Mutch) Messrs. M. H. Mackeith, A. T. Rogers, and J. K. Milward.

Dressers to Surgical Units (second three months).—(Sir A. Fripp) Mr. T. E. Jones; (Mr. Steward) Mr. H. W. Taylor; (Mr. Rowlands) Mr. M. E. Shaw.

Obstetric Dressers (six months).—Messrs. M. T. Ahmed S. Annecke, F. Bekker, G. C. Curson, H. O. Eksteen, E. Hardy, H. W. Harvey, R. J. Hodgkinson, B. Kessel, G. B. Kirkland, T. J. Lane, F. L. Rayner, E. H. Richards, A. H. Shelswell, C. Short, A. E. Strawbaun, and R. E. Williams.

Externs.—July 16th to August 15th, Messrs. R. E. Williams and G. C. W. Curson; August 16th to September 15th, Messrs. S. Annecke and A. H. Shelswell; September 16th to October 15th, Messrs. M. T. Ahmed and H. O. Eksteen.

Clerks in the Children's Department.—

(1) *Dermatology.*—Mr. L. R. A. Wells.

(2) *Neurology.*—Messrs. J. B. Gregor and L. K. Watson.

Clinical Assistants (Dr. French and Dr. Poulton).—Messrs. S. Cohen, E. T. Lloyd, A. Mackenzie, E. J. Crisp, G. K. Reeves, and H. A. Pargeter.

Clerks or Dressers in Special Departments.—

Ophthalmology.—(Mr. Eason) Messrs. I. W. Arnovitch and E. F. Wilson; (Mr. Ormond) Mr. J. Sullaiman.

Ophthalmology (Mr. Ormond) *and Laryngology* (Mr. Mollison).—Mr. M. Hall.

Genito-Urinary.—Mr. P. L. Richardson.

Orthopædics.—Mr. P. Couacoud.

Pathological Assistant to the Demonstrators of Morbid Anatomy.—Mr. F. W. Widgery.

Guy's Hospital.

July 9th, 1920.

The following appointments have been made by the Treasurer upon the recommendation of a Staff Meeting:—

Medical Registrars and Tutors.—Messrs. T. I. Bennett, J. M. H. Campbell, G. B. Dowling, and —. Vertue.

Medical Assistants.—Messrs. J. J. Conybeare and A. A. Osman.

Surgical Registrars and Tutors.—Messrs. W. H. Ogilvie, F. Cook, J. Joffe, and J. G. Jones.

Surgical Assistants.—Messrs. W. E. Tanner, P. D. Scott, T. G. D. Bonar, and E. Biddle.

Gynæcological Assistant and Registrar.—Mr. C. H. Medlock.

Midwifery Assistant and Registrar.—Mr. A. J. McNair.

Chief Clinical Assistant and Registrar to Neurology Department.—Mr. J. F. Venables.

Chief Clinical Assistants and Registrars to Ophthalmic Department.—Messrs. O. G. Morgan and C. H. St. John.

Chief Clinical Assistant and Registrar in Throat and Ear Department.—Messrs. P. D. Scott and N. E. Kendall.

Chief Clinical Assistant in Children's Diseases Department.—Mr. A. A. Osman.

Clinical Assistants (Female) to Obstetric Surgeons, V.D. Department.—Misses D. C. Logan and G. Wilson.

Junior Assistant Bacteriologist.—Mr. E. Biddle.

Chief Clinical Assistant and Registrar Orthpædic Department with charge of Workshop.—Mr. A. H. Todd.

Resident Medical Officer, Bright Ward.—Mr. J. Victory.

Assistant Anæsthetists.—Messrs. G. L. Attwater, N. E. Kendall, V. E. Lloyd, and C. H. St. John.

Anæsthetist to Bright Ward.—Mr. A. D. Marston.

Demonstrators of Physiology.—Messrs. C. Lambrinudi, W. H. Ogilvie, T. I. Bennett, and D. O. Richards.

Demonstrator of Anatomy.—M. C. S. L. Roberts.

Demonstrators of Anatomy (part time).—Messrs. R. C. B. Ledlie, J. A. Berry, T. G. D. Bonar, and J. F. C. Braine.

Demonstrators of Chemistry.—Messrs. J. O. Cutter and A. Greeves.

Demonstrator of Biology.—Mr. T. Reed.

Demonstrator of Public Health.—Mr. H. W. Southgate.

Demonstrator of Morbid Histology.—Mr. St. G. B. D. Gray.

Demonstrators of Pathology.—Messrs. R. C. B. Ledlie and H. W. Southgate.

Demonstrators of Prosthetic Dentistry.—Messrs. J. Herbert and H. L. Messenger.

Demonstrators of Practical Dentistry with charge of Probationary Classes and Ordinary Extractions.—Messrs. A. B. Aldred and J. A. S. Wright.

Demonstrators of Operative Dentistry with charge of Gas Room.—Messrs. E. H. Bryant and H. Millett.

Resident Dental Officer.—Mr. E. R. Bailey.

Dental Sub-Dean.—Mr. F. B. Bull.

Dental Radiographer.—Mr. H. M. Worth.

Anæsthetists to the Dental School.—Messrs. A. D. Marston and E. A. Scott.

Assistant Dental Anæsthetists.—Messrs. E. R. Bailey, A. H. Todd, G. L. Attwater, and A. Ll. S. Payne.

The following appointments have been made by the Court of Committees on the recommendation of a Staff Meeting:—

(From October 1st, 1920, to September 30th, 1921).

Chief Clinical Assistant in the Dermatological and Venereal Diseases Departments.—Mr. G. B. Dowling, M.D.

Chief Clinical Assistant in the Genito-Urinary and Venereal Diseases Departments.—Mr. G. T. Mullally, M.B., B.S., F.R.C.S.

Chief Clinical Assistant to the Obstetric Surgeons in the Venereal Diseases Department.—Miss Morna Rawlins (Mrs. Vaughan), M.B., B.S.

Chief Clinical Assistant (Senior Assistant Bacteriologist), Bacteriological Department, and Medical Officer, V.D. Clinic.—Mr. T. Skene Keith, M.B., B.S.

Anæsthetist to the Hospital.—Mr. Eric A. Scott, M.R.C.S., L.R.C.P.

Honours.

MILITARY.

Included in a list of officers mentioned in despatches by General Sir G. F. Milne for continuous distinguished and devoted service during the evacuation of the Caucasus:—

Capt. (Acting Major) G. Y. Thomson, I.M.S.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

In view of the fact that the Boat Club has just been re-started, the following letter received by the Honorary Secretary of the Clubs' Union may be of interest:—

Renter's Office,
Guy's Hospital,
London, S.E.1.
1st July, 1920.

DEAR SIR,—In the recent reconstruction of the Hospital Muniment Room, certain Challenge Cups and Oars were brought to notice which were evidently the property of Guy's Boat Club from 50 to 75 years ago.

As this Club has long ceased to exist, the Governors considered that they should be in the custody of the Clubs' Union, and I was instructed to hand them to you with a view to their being placed with other trophies of a similar character.

The articles, which accompany this letter, are as follws:—

Pair of silver Challenge Cups presented by Peter White Thompson, 1846.

Pair of silver Challenge Sculls (in mahogany case) presented by Thos. Callaway Junior, 1846.

Pair of gold(?) Challenge Oars (in two leather-covered cases) presented by Thomas Evans, 1846.

Please be so good as to acknowledge receipt.—Yours faithfully,

R. W. ROBBINS,
Renter and Registrar.

The Secretary,
Guy's Hospital Clubs' Union.

Change of Address.

B. E. Jerwood, M.R.C.S., Oakham, Rutland.

Stephen Keele, from 5, Upper Wimpole Street, to 19, Park Crescent, Portland Place, W.1.

C. Meadows-Ryley, from 62, Queen Anne Street, W.1., to 11, Welbeck Street, W.1.

R. Sells, Crinnis House, Southend-on-Sea.

Col. W. Sheen, R.A.M.C., C.B.E., M.D., M.S., F.R.C.S., 69, Wimpole Street, W.1. (Phone Mayfair 3177).

Major G. Y. Thomson, I.M.S., M.B., B.S., 48th Indian General Hospital, Constantinople, Army of the Black Sea.

Harold Webb, 10, Egerton Road, Bexhill, Sussex.

Coffin, S. W., from 37, Willifield Way, to 60, Temple Fortune Lane (Phone, Finchley 1769).

Dr. Lloyd Smith, The Old Country Club House, Llandrindod Wells.

Notes on Small Pox.

The cases appended, 37 in number, were under my care at the Orsett Small Pox Hospital.

The first was admitted on January 15th, and the last discharged on May 30th, 1920. Although comparatively few in number, they illustrate almost every type of the disease, and as smallpox is a relatively rare disease I thought these notes might be of interest. During the ten years I have been Medical Officer to this Hospital, we have had six threatened epidemics, of which this is the worst, the largest previous number of cases being six.

They have mostly owed their origin to cases from ships. For example, a man goes ashore at Port Said, and walks into my surgery 14 days later with the smallpox rash on his forehead, having in his own words "dodged the ship's doctor." Another case I remember was a steward who arrived home and developed delirium tremens with a history of heavy spirit drinking. His temperature was 104°,

Number.	Sex.	Age.	Vaccinated.	Re-vaccinated.	Not Vaccinated.	Degree of Severity.	Result.	
1	F	20	Inf.			V	Recovered	
2	F	41	Inf.			IV	"	Prodromal "bathing drawers rash."
3	M	45	Inf.			IV	"	
4	M	6			N	II	Died	Died on 12th day after admission.
5	F	46	Inf.			III	Recovered	Mother of 4 and 6.
6	F	24			N	II	"	Very severe attack. Multiple abscesses. Severe corneal ulceration. One eye sight nearly lost.
7	M	40	Inf.			III	"	
8	F	27	Inf.			V	"	
9	F	30	Inf.			V	"	
10	M	31	Inf.			V	"	
11	F	9				VI	"	Daughter of 9 and 10. Vaccinated after infection. Only a few modified pocks.
12	M	22			N	II	"	Very severe attack.
13	M	19	Inf.	R		VI	"	An extremely mild case.
14	F	3			N	II	Died	Died on 9th day after admission.
15	F	5			N	II	"	Prodromal morbilliform rash. Died on 4th day after admission.
16	M	34	Inf.			IV	Recovered	Had delirium tremens after admission.
17	M	7 wks			N	II	Died	Died on 2nd day after admission.
18	F	46	Inf.			II	"	Died on 3rd day after admission. Prodromal "bathing drawers rash." The only case lost that was vaccinated.
19	F	36	Inf.			V	Recovered	
20	M	32	Inf.	R		VI	"	Very mild case.
21	M	7			N	III	"	
22	F	18			N	III	"	
23	M	17	Inf.	R		VI	"	Mild case, but suffered from multiple boils.
24	M	9			N	IV	"	Gave small pox to both parents and three sisters.
25	M	47	Inf.	R		VI	"	Husband of Case 18. Re-vaccinated after infection.
26	M	28	Inf.			V	"	
27	M	6			N	IV	"	
28	F	42	Inf.			V	"	
29	M	2			N	II	Died	Died 3rd day after admission.
30	F	14			N	IV	Recovered	
31	M	13			N	IV	"	Son of Cases 19 and 32.
32	M	37			N	III	"	
33	F	56	?			II	Died	Died on 10th day after admission. "Bathing drawers rash." Mother of Case 34.
34	F	18			N	I	"	Hæmorrhagic case. Died after her confinement, before she could be admitted to hospital.
35	M	60	Inf.	R		VI	Recovered	Alastrim (?). See notes. Re-vaccinated after infection.
36	F	61	Inf.	R		VI	"	Alastrim (?). Re-vaccinated after infection. Sister-in-law of Case 35.
37	F	20			N	II	Died	Died on 9th day after admission. "Bathing drawers rash."

and I thought he was probably developing pneumonia till the rash appeared. Fortunately, in both these cases no one else was infected, and I merely mention them to show the risks run by a town with a large maritime population.

The cases are graded:—

1. Hæmorrhagic.
2. Confluent.
3. Semi-confluent.
4. Discrete.
5. Mild discrete.
6. Varioloid and other modified cases.

It will be noticed that of nine fatal cases only one had been vaccinated.

Case 33 was said to have been vaccinated, but no marks could be detected.

The four re-vaccinated cases were all mild. There were four cases of "bathing drawers" prodromal rash cases, 2, 18, 33, 37, with three deaths.

The only case, 15, of prodromal morbilliform rash was also fatal.

Case 34 was hæmorrhagic and died before she could be admitted.

Case 12 was very severe. He was an officer in the Army, and, curiously enough, had never been vaccinated, though he was never an anti-vaccinator.

Cases 35 and 36 were extremely interesting. They were a brother and his sister-in-law.

In the case of the man the rash was very profuse, but the man was never very ill. The rash had not the normal distribution, being plentiful on the abdomen, which is not the case with ordinary smallpox. His chief trouble was an eruption of large bullæ resembling pemphigus during the later stages of the disease. He was seen by several specialists who suggested "Alastrim" as a diagnosis. This term has been used to describe "certain epidemics of an infectious eruptive disease which has been variously held to be a different form or a mild form of smallpox."

It differs from ordinary smallpox: (1) low mortality, 5 per cent. (2) absence of secondary fever (3) absence of characteristic smell of smallpox (4) no deep scars (5) short duration of immunity against vaccinia. Alastrim is common in Brazil.

In Case 36 the rash was very slight and the patient was not ill at all.

On the whole I should say they were merely modified cases of smallpox of an abnormal character. I may add that they had both just been re-vaccinated.

Of the 37 cases 16 were from the district; 21 were from outside.

Five cases from the district were sent away to another hospital as we did not have sufficient accommodation. These all recovered.

I beg to thank Mrs. Taylor, the Matron, for her devotion to the patients and for her assistance in keeping the records. S.G.F.

The Johns Hopkins Hospital.

Having been admitted as an intern to the Psychiatric Clinic through the kindness of Professor Adolf Meyer, I have had a good opportunity of comparing the conditions here with those at Guy's. It is necessary to explain at the beginning that this Hospital occupies a position which is perhaps unique in this country, and has no exact analogy in Great Britain. Its standing in the world of Medicine, together with its financial independence, enables it to select its students as follows:—Every entrant must have passed the required examination in preliminary scientific subjects, must have obtained the degree B.A. or B.Sc. of a recognised University, and must furnish evidence of a reading knowledge of French and German. The number of entrants annually is limited to ninety, and these begin their training as a group on October 1st, the opening of the academic year. There are on an average four hundred applicants each year possessing the necessary qualifications, from whom the ninety are selected upon their University records and letters of personal recommendation from their past teachers.

The course consists of four years' work, each year being divided into three trimesters, the period July to September being left vacant on account of the heat, which puts a stop to routine teaching. These years are spent roughly as follows:—

Year 1.—Trimesters I and II are spent at Anatomy, including Histology, Embryology, and the study of normal X-ray appearances. Anatomy seems to be taught from a more physiological standpoint than with us, and gains therefrom, and the inclusion of Histology in this period gives the subject a more vital interest. The student is required himself to dissect out from the pig (a large quantity of still-born pigs being provided for the purpose) specimens of muscle, nerve, liver, intestine, etc., and thus to prepare for himself sections of each kind of tissue, this work being carried out side by side with gross dissection of the human body. A special course is given in the anatomy of the central nervous system.

Trimester III is devoted to Physiology and Bacteriology.

Year 2.—Trimester I is spent on work at Physiology, Pharmacology and Pathology, a certain amount of anatomical work being carried on at the same time.

Trimester II. Physiology is dropped, Pharmacology and Pathology are carried on, together with some Anatomy, and certain elective subjects are included, the student being required to perform under supervision some experimental work of his own in

one of the subjects he has already studied. At the end of this trimester the records of all students are reviewed, an examination is held, and those who fail are advised to withdraw from the school.

Trimester III is devoted mainly to elementary clinical instruction in diagnosis, physical signs, clinical laboratory routine, etc., with out-patient clerking and attendance in the post-mortem room.

Year 3.—This is spent entirely in clinical work, partly in out-patient clerking, partly in attendance at special ward rounds and clinical demonstrations with which each day is entirely filled. Compulsory courses are given in Medicine, Surgery, Gynæcology, Obstetrics, Neurology, Psychiatry, Clinical Microscopy and in examination of the fundus oculi and larynx. In addition, there are special subjects of which any student may take up one or more at his discretion, including Operative Surgery, Tuberculosis, the Cardiac Arrhythmias, etc. The operative surgery is performed, not on the preserved cadaver, but on anæsthetized dogs with proper surgical technique and instruments—an opportunity denied us by the Anti-Vivisectionists. At the end of this year a second examination is held, no candidate being allowed to go on to the fourth year until he has passed it, and any candidate failing in two major subjects being required to withdraw from the school.

Year 4.—Trimester I. The student becomes a surgical dresser. He is responsible for the notes of his cases under the very careful supervision of the intern, and each dresser has beds in the wards for Genito-Urinary diseases, Orthopædics and Gynæcology, as well as General Surgery.

Trimester II. He becomes medical ward clerk, his case-taking being again done under the supervision of the intern. Six hours a week are spent in work in the clinic for Children's Diseases, a separate block containing eighty beds.

Trimester III is spent in special work in the departments of Medicine, Surgery, Children, Genito-Urinary Diseases, Gynæcology, Neurology, etc., at the choice of the student.

At the end of the first trimester of the fourth year selection is made from the men of the year, of thirty who will proceed to a fifth year's work as interns. They are finally allotted their respective departments at the end of the fourth year in order of choice according to merit. The medical degree M.D. is awarded on a pass examination at the end of the fourth year, but a State Board examination has to be passed before the graduate receives his license to practice, and in this State and some others the Board requires the candidate to have spent one year after graduation as an intern in a recognised hospital before presenting himself for examination. This means that unsuccessful applicants for internships at this Hospital have to seek posts elsewhere, in the State hospitals which correspond to our infirmaries. The position of the intern is something between a glorified ward clerk or full dresser and an house physician or house surgeon. His appointment is for one year, he lives in the Hospital, being provided with board, lodging and laundry, but without salary, and is responsible for the treatment of patients in his beds under supervision of his superior officer, the Resident, as well as for the compilation of his case records. The thirty interns are split up among the different departments, five each in Medicine and Surgery, fewer in other branches. In each Department there is a Resident, and in most one or more Assistant Residents, who are selected from past interns and may remain for several years. I can perhaps give the clearest picture of the intern's duties and his relations to the Resident by describing my own position in the Psychiatric Clinic. I have a ward of twelve beds, attached to which is an office for private interviews, with patients, keeping notes and performing lumbar punctures, etc. On admission of a new case, I take a history and proceed to make a physical and mental examination according to schedule. The routine for physical examination is a formidable affair, all negative information having to be entered, including on each case blood pressure, rectal examination, and, in a woman, pelvic examination, a note on the ophthalmoscopic appearances, estimation of hemoglobin, white blood count, microscopic examination of urine for casts and fæces for parasites. The recording of all this is simplified by the dictaphone, which is used everywhere. Once accustomed to the routine, the intern makes rough notes at the bedside, and afterwards, armed with a copy of the routine schedule, dictates the record, receiving it typed within twenty-four hours. I may order special examinations, such as X-ray, through the Resident, and am required myself to do such examinations as test-meal estimations and phthalein excretion of the kidney. I make a morning and evening round, order treatment, and attend the visiting staff on their rounds armed with writing pad and pencil to record verbatim their remarks upon each case to be incorporated in the notes. In addition, the interns in this clinic take in turn for periods of three months the duties of laboratory assistant doing Wassermanns, blood sugars and other special work, and anti-syphilitic treatment. In General Medicine there are two special features. Every fifth day each medical intern is responsible for extern work, i.e., if a general practitioner telephones to the Hospital that he has a case requiring admission and unable to attend out-patients, the extern goes out to see it and decides if and where it shall come in. Baltimore has a population of 700,000, and possesses a State Hospital with over a thousand beds, well equipped, besides other smaller institutions, and the Johns Hopkins Hospital, not being dependent upon

public subscription, is able to select its cases for admission on the basis of their value as material for clinical teaching and investigation. Thus, very little casualty work is accepted, and nearly all patients coming to out-patients are referred by doctors. The second feature of the medical intern's work is that for two months out of his year he is responsible under supervision for all the routine medical bacteriology at the Hospital. For this he has a splendidly equipped laboratory, with an expert technician, a second man to clean up, and a woman to run errands, sterilize glass, and so on. The duties include vaccine preparation and therapy blood cultures, blood matching and transfusion and all routine salvarsan administration to in-patients.

The Resident of each service is entirely responsible for the treatment of patients under his care. He makes his rounds attended by interns and clerks, teaches and records his impression of each case. The visiting staff have no beds, but on their rounds examine and teach on any case of interest which they may choose, or to which the Resident draws their attention. Thus, a puzzling case is seen by the Resident and several members of the staff, each of whom teaches upon it and records his impression.

On Wednesday morning, at noon, in the Post mortem Room, Dr. Thayer, Professor of Medicine, first summarises the notes of the cases who have died in the medical wards during the week, and is then presented with the organs obtained at autopsy by Professor McCullum of Pathology, who, in his own words, "discusses with as much acrimony as possible" the features of the case. On Friday afternoons there is another meeting for the staff only, between Clinicians and Pathologists, at which I understand the divergencies between bedside interpretations and dead house facts are discussed with even greater frankness.

It will be judged from this account of the curriculum that the man who completes his studies at the Johns Hopkins with a fifth year as intern is a very highly finished product of special training. First and foremost, he must be capable of assiduous, patient work to have reached this position; his earlier studies have given him a laboratory training which qualifies him for research; he has every method of modern technique at his fingers ends; he has studied the minute details of his cases in a way that is hardly ever done with us and leads to a very healthy independence of text-book dicta. He is excellently fitted in most cases for research or consulting work, and it is this which the majority of graduates take up. In their teaching the staff have not to consider the needs of the man who is going into general practice.

The whole intellectual atmosphere is as stimulating as the climate is depressing, and these are superlative terms: *experto crede*! Yet there is something missing which we have at Guy's and they have not, some intangible quality the lack of which is felt more plainly than it can be described. Perhaps the scrupulous attention to detail is achieved at some sacrifice of general comprehension, and the desire for minute accuracy leads to a suspension of judgment in diagnosis which we in our British manner would call unsporting. Perhaps it is that the hustle and rush of competition and the grind of elaborate routine leave room for too little of the friendly personal relations which obtain between the house physician and the Borough. Moreover, the men in the house allow very little time for relaxation; the presence in all parts of the Hospital of megaphone attachments from which his name is called from a central telephone office if he is wanted, allows the house officer little rest; meals are hurried through on the way to more work; and shop is talked between mouthfuls. Purely scientific achievement brings its own rewards, but to the ordinary mortal half measure of satisfaction; one feels sometimes that a little bread throwing at the residents' table would be all to the good.

How far the finished product of the Johns Hopkins Hospital would be suited for consulting work in England it is hard to say. He strikes one as being almost too dependent upon minute laboratory examinations. The many special tests which he has been trained to consider essential before pronouncing a definite opinion would not appeal to the general practitioner or his patients. But it is to be remembered that the medical education of the lay public here is in striking contrast to that of Great Britain. The casual labourer is not content with a "bottle of medicine," but expects a systematic physical examination. Every man in the street knows the meanings of the terms Blood pressure and Wassermann test. The high standard of scientific work which obtains here must depend to a large extent on financial resources. There are many whole-time workers in departments of both teaching and research, laboratories are excellently equipped, not only with apparatus, but with skilled technicians. There is a first-class medical library, and there are rooms and staff enough at out-patients to enable all departments to work simultaneously every day of the week, so that you may refer a case from Medicine, for instance, to Neurology and Gynæcology, and, receiving their reports written in detail, complete your diagnosis the same morning. Here, Scientific Medicine is practised and taught under optimum conditions—high ideals are attained and high standards arrived at. It is a great place to work in, and the kindness of the residents makes it a pleasant place to live in—in spite of the climate.

C. P. S.

Baltimore,
July 4, 1920.

Guy's Hospital Boat Club.

A General Meeting was held a few weeks ago, and it was decided to form a Rowing Club in connection with the Hospital. Mr. Davies-Colley was elected president and Dr. Ryffel vice-president; the committee was to consist of five members and the secretary. The following were elected:—

Committee.—Messrs. M. E. Shaw, F. N. Roberts, J. C. Rowbotham, G. C. Hughes, R. R. Mackintosh.

Hon. Secretary.—F. C. Miller.

It was decided to call the club "The Guy's Hospital Boat Club," and that it would be most advantageous to affiliate with the London Rowing Club, to use their premises, their boats and their coaches, and give them the services of Guy's members who are willing to row for them.

At another meeting held on the 13th July it was announced that a four was being entered for the Inter-Hospital race, to be held on July 31st, and also that a four would be going out regularly with a view to getting a more representative boat for next year's events. It was urged that as many members as could join should do so as soon as possible, and give their names to the secretary in order to arrange some club events.

There are a pair of silver challenge cups for pair-oared races, also challenge oars and sculls, to be competed for, and it is hoped that there will be a sufficiently large membership before next year to hold a small regatta of our own.

The Clubs Union are giving a grant which will cover the yearly subscriptions, leaving only the entrance fee of £2 2s. to be paid by members on joining.

F. C. MILLER,
Hon. Sec., G.H.R.C.

Cricket.

GUY'S SECOND XI. v. BEDDINGTON SECOND XI.

Played at Honor Oak Park on May 15th.

Batting first on a perfect wicket, we gave a feeble display, being all out in an hour and a-half for 76.

Beddington started well, getting fifty before tea without loss, but collapsed badly afterwards. Hewitson bowled well, getting six wickets for only 27 runs. Scores:—

Guy's Second XI.

G. L. Shearar, run out	7
F. R. Payne, c Grays b McDonald	16
L. N. Theron, c Sub b McDonald	0
J. D. S. Thomas, c Griffin b McDonald	0
D. C. Eglington, b McDonald	13
H. Slater, b Kent	8
J. C. Rowbotham, b McDonald	13
—. Houghton, b McDonald	3
R. F. H. Duncan, c McDonald b Kent	0
L. Fisher, b Kent	7
—. Hewitson, not out	7
Extras	2
Total	76

Beddington Second XI.

Latham, b Payne	29
McDonald, b Hewitson	36
White, b Hewitson	0
Graves, b Hewitson	12
Kent, b Hewitson	2
Hayton, b Hewitson	0
Griffin, not out	8
Harvey, b Hewitson	0
James, b Payne	0
Packwood, c Shearar b Payne	7
Chase, b Payne	0
Extras	19
Total	113

GUY'S SECOND XI. v. ST. DUNSTAN'S COLLEGE.

Played at Catford on Saturday, May 24th. Although losing the toss, we batted first on a perfect wicket. Shearar and Pengelly opened the innings and made 58 before Pengelly was bowled. Shearar continued to play good cricket, and compiled a useful 64. Duncan played a very fine innings for 71, and had very hard luck in being stumped, the ball rebounding off the wicket-keeper's pads on to the wicket. Slater made his 43 in a very short time.

St. Dunstan's made a good fight, Waring batting well for his 34, but Fauré, who kept a perfect length throughout, was too good for them, taking 7 wickets for 68. Scores:—

Guy's Second XI.

G. L. Shearar, c Frosate b Sheridan	64
R. G. Pengelly, b Waring	20
W. F. Payne, c Waring b Frosate	6
Newberry, c Wood b Sheridan	7
R. F. H. Duncan, st Wanbrough b Waring	71
D. C. Eglington, b Waring	5
J. D. S. Thomas, b Noble	12
H. Slater, c Morris b Noble	43
C. G. Bowen, b Whicker	0
J. C. Fauré, not out	3
L. N. Theron, not out	0
Extras	12
Total	243

St. Dunstan's College.

H. J. Whicker, c and b Fauré	12
T. G. Claxton, c Slater b Fauré	6
C. J. Waring, b Bowen	34
V. C. Wanbrough, b Fauré	15
E. A. Wood, c Newberry b Theron	12
C. B. Mullen, b Theron	2

V. Frosate, c Shearar b Fauré	24
H. Noble, c Eglington b Fauré	2
G. C. Bennett, b Fauré	15
H. W. Morris, b Fauré	40
P. H. Sheridan, not out	1
Extras	10
Total	173

GUY'S v. BECKENHAM.

Played at Honor Oak Park on Saturday July 10th, and lost by 196 runs. At the start, with Beckenham batting first, everything looked rosy—the board showing five for 74 and six for 110. But C. T. A. Wilkinson, the Surrey captain, and W. A. Powell obtained the mastery of our bowling, and took the score to 219, both batting well. The visitors declared at tea for 256 for nine. The Hospital then put up a very poor show, of which the least said the better. Let the score speak for itself. Scores:—

Beckenham.

D. H. Butcher, run out	22
D. M. P. Whitcombe, c Shearar b Schalkwijk	7
J. K. Stenning, c Fauré b Schalkwijk ...	10
R. Curwen, b Schalkwijk	14
P. J. Aste, c Wooldridge b Fauré	13
E. Hart, b Schalkwijk	22
C. T. A. Wilkinson, c Wooldridge b M.-Smith	86
W. A. Powell, c Schalkwijk b Bowen ...	43
J. H. Todd, not out	23
R. S. Gladhill, c Duncan b Muir-Smith ...	1
W. A. Barnes, not out	5
Extras	10
Total (for 9 wickets dec.) ...	256

Guy's.

E. H. Muir-Smith, c Butcher b Powell ...	15
J. Van Schalkwijk, c Stenning b Barnes ...	10
T. Wooldridge, c Powell b Stenning	7
G. L. Shearar, b Stenning	1
A. L. McKay, c Gladhill b Stenning	10
J. C. Hewetson, c Butcher b Powell	12
J. C. Fauré, b Powell	4
L. B. Helder, c Butcher b Powell	0
R. F. H. Duncan, c Stenning b Powell ...	0
J. D. S. Thomas, b Stenning	1
C. G. Bowen, not out	0
Extras	6
Total	66

W. A. Powell, 5 for 14; J. K. Stenning, 4 for 34.

GUY'S HOSPITAL v. GRAVESEND.

This game, played at Gravesend on Wednesday, July the 14th, was productive of most extraordinary cricket. The Hospital, batting first, had an early collapse, six wickets falling for 25; but Muir-Smith, assisted by McKay and Fauré, saved a "rout"—the former's innings was a capital one. Wilkinson (Glos.) found the wicket to his liking, and was extremely difficult to play. When Gravesend went in to bat Schalkwijk bowled A. W. Pegrum with his second delivery, and six wickets fell in the first half dozen overs for five runs, after which they totalled only 41. Each side had a little further batting. The Hospital fielding was good, and the bowling honours rested with Schalkwijk, 6 for 16, and Fauré, 4 for 20. Scores:—

Guy's.

L. C. Willis, b Wilkinson	1
C. Vincent Brown, b Ashwell	3
E. H. Muir-Smith, b Wilkinson	50
J. Van Schalkwijk, b Wilkinson	0
L. B. Helder, b Wilkinson	1
W. H. Willis, b Wilkinson	4
G. L. Shearar, c Wilkinson b Ashwell ...	6
A. L. McKay, b Wilkinson	18
J. C. Fauré, b Edwards	22
H. Slater, c Wilkinson b Edwards	3
F. R. Payne, not out	0
Extras	0
Total	108

Gravesend.

H. B. Pegrum, c W. H. Willis b Schalkwijk	0
A. W. Pegrum, b Schalkwijk	0
J. Wilkinson, c McKay b Fauré	14
P. R. Bleake, c Fauré b Schalkwijk	1
Rev. P. Hall, b Schalkwijk	0
E. Tanner, b Fauré	0
W. H. Humphries, b Schalkwijk	0
W. Foster, b Schalkwijk	3
A. L. Tulk, b Fauré	12
H. P. Ashwell, not out	6
H. Edwards, l.b.w. b Fauré	0
Extras	5
Total	41

GUY'S v. HONOR OAK C.C.

Played on the ground of the Honor Oak C.C. on Saturday, July 17th, and resulting in a draw.

Honor Oak won the toss, and after a slow start eventually declared their innings closed with the score 258 for three.

Cook batted faultlessly for 93.

Guy's could only manage to score 116 for 9, of which Muir-Smith made 54, a really fine innings. Wooldridge batted well. Honor Oak's bowling was very good. Scores:—

Honor Oak.

C. W. Lamb, l.b.w. b Van Schalkwijk ...	22
W. Gracey, l.b.w. b Fauré	36
W. Cook, b Van Schalkwijk	93
J. H. Lockton, not out	78
Extras	30
Total (for 3 wickets)	258

Did not bat: A. Kempton, G. A. Abel, L. Thompson, Dr. W. J. Cherry, C. Wise, S. Anson, A. R. Thorpe.

Guy's.	
E. H. Muir-Smith, b Cherry	54
C. Vincent Brown, c Cherry b Lockton ...	0
T. Wooldridge, c Kempton b Lamb	29
G. D. Shaw, b Cherry	3
L. B. Helder, l.b.w. Cherry	1
L. C. Willis, b Cherry	4
G. L. Shearar, b Lockton	0
J. Van Schalkwijk, b Lockton	6
W. H. Willis, st Kempton b Cherry	0
J. C. Fauré, not out	6
F. J. Biddle, not out	3
Extras	10
Total	116

116 runs for nine.

Reviews.

The Mental Hygiene of Childhood. By William A. White (Messrs. Wm. Heinemann) price 6s. net.

"Education has captured psychology!" was the triumphant dictum of one of our eminent educationists a very few years ago. But the book before us, typical as it is, indicates that captive Greece has not only already taken captive her rude conqueror but is proceeding to avenge herself on him for his former presumption. Dr. William White, the superintendent of St. Elizabeth's Hospital, Washington, is one of those psychiatrists who believe that the generalisations evolved during the course of psychotherapeutic practice are sufficient to form a foundation upon which parents and teachers—that is, those who have to superintend the upbringing of the normal child—may profitably work. He is anxious to point out how much depends upon childhood, and that more depends upon the environment of the child than on his hereditary endowment. He wishes to awaken people to the dangers and difficulties of youth; to give the guardian of the child some knowledge of the infant mind, of its psychology, and more particularly of the instinctive bases of conduct. Few interested in the welfare of children would be inclined to take exception to this admirable project. But it must be admitted, at the outset, that the book fails to carry out the scheme of its author. We feel that all the careful thought requisite to the writing of a brief and popular work has not gone to the making of this. This is lamentable, though hardly to be wondered at, for it is not yet widely recognised that the "general public" need accurate and concise fare if their minds are to benefit. Dr. White, in his eager advocacy of his case, has omitted to present aspects of the subjects he discusses which can never to-day be neglected in any consideration of them, however popular. In writing of instinct, he says "Different authors have reached different conclusions as to the number and character of man's fundamental tendencies. . . . The most recent thought, however, tends to reduce them all to expressions of but two prime instincts which are characteristic, not only of man, but of all living things, namely, the self-preservative ego-instinct and the race-preservative or sex-instinct." We fear that even a psycho-analyst cannot afford to neglect the work of Mcdougall, more especially here as it has been embodied in a popular form. This is no mere academic or patriotic quibble—it is our firm belief that if we are to have a psychological theory of infancy, in no respects must it be so impregnable as in its conception of the instinctive tendencies. And were Dr. White only clear about his own classification we might find less to object to; but what are we to say when on page 27 he classes gluttony and purely selfish indulgence as part of the ego-instinct while on page 30 personal luxury appears as part of the sex-instinct? This brings us to the distinctive characteristic of the book—its insistence upon sex as the root of *all* conduct. In saying this we do not distort Dr. White's point of view. Even if we admit the importance of the sex-instinct, surely it must be confusing for a reader to whom the idea of infantile sexuality is new to be told that *every* pleasure is primarily sexual—even football apparently ("muscle erotism" page 82). Any parent who were to base the education of his children upon the ideas he might derive from such a treatment would be making trouble. Then, too, Dr. White associates the child's curiosity about its origin, with sex. He says "curiosity is frequently displayed about sex matters," not realising that while birth is a matter of sex to the adult it is not so to the child *before he is told.* Would Dr. White admit the only other possibility—that the child knows while he asks? Surely if there is a sexual basis for this sort of curiosity it is subconscious and not conscious. Dr. White would be the first to deny that no good proceeds from amateur tinkering with the sub-conscious. In his own advice to parents he treats this matter, rightly, as one, first of all, not to be connected with sex. But this advice is unfortunately very vague. The book, however, has its value. This lies in its presentment of facts and theories to a class of readers probably not very familiar with them. The danger is here as always with this sort of book, that it will not get into the hands of these readers. This is no fault of the author's: given its proper audience, the book can be of no little use in acquainting parents and teachers with some of the fundamental factors of child life and in arousing in them a sense of the possibility of danger. But to fulfil this function adequately, the book, it seems to us, should undergo certain modifications. First of all, as it is suggestive rather than informative, it must be supplemented by wider reading, and a list of suitable books

should be appended. The names given in the footnotes are mostly of articles in professional periodicals, of a kind not easily read by those for whom this book is intended, and altogether too narrow in scope to be of much use. Second, we feel that it is a mistake that the book is so highly controversial at every stage. If the advocate is preferred as livelier than the judge, let there at least be some indication of another standpoint. Finally, the whole should be clearer in statement: for this is a matter of the utmost importance in a work professedly popular.

Harrison's *Manual of Venereal Diseases for Students.* (Messrs. Hodder & Stoughton) price 16s.

As a manual of venereal diseases Col. Harrison's work is excellent, but as a book which is intended primarily for students it does not quite fulfil its object. The student must, of course, have some familiarity with venereal disease before qualification, but he is already so burdened by the amount of knowledge which he must acquire that one would think that the chapters on syphilis and gonorrhœa which are found in a good text-book of surgery should be sufficient for him. A book of 342 pages is surely too much. Apart from this rather obvious fault, Col. Harrison's book is extremely good. The author gives a complete and clear description of venereal diseases, which will be of great benefit to the practitioner, or even to the specialist. He has amplified his earlier volume, "The Diagnosis and Treatment of Venereal Diseases in General Practice." He has retained all that was so good in that work, but has now gone more thoroughly into the pathology of the diseases. The chapters on examination and treatment are particularly helpful. Some good extra illustrations have been added. The arrangement of the materials, the clearness of the descriptions, combined with Col. Harrison's great experience, make the book one of the greatest value. There is no work of its size on the subject which can be more wholeheartedly recommended.

Students' Synopsis Series: Pharmacology. By Douglas Cow, M.D. (Published by J. & A. Churchill, (London), pp. 132). Price 7s. 6d.

This is the first of a new series of small books written for the student who wishes to revise his work in a short space of time. In the preface the author points out that it is intended, not to replace the larger works on pharmacology, but rather to help the student to mobilise the knowledge he has gained by previous reading and experiment.

The matter of the book is arranged alphabetically and includes accounts of drugs and their actions on all the various organs, together with a consideration of the systems of the body and the substances which act on the various point therein. The latter are illustrated by excellent diagrams of the bloodvessels, heart, glands, etc., and their innervation, and clearly indicate which drugs act centrally, peripherally, and in between—stimulating or inhibiting as the case may be.

One or two points are worthy of criticism; thus, the excretion of hexamethylene tetramine into the cerebrospinal fluid is not mentioned, nor is the application of artificial respiration in cases of morphine poisoning. Again, the author omits to mention the doses of several drugs (*e.g.*, Filix Mas).

However, these are all minor points. As a whole the book is clearly and interestingly written, and in a few pages all the important pharmacological facts are set down.

The work is primarily dedicated to: "That Great Army of Medical Students, some eighty per cent. of the whole who in examinations are within measureable distance of the Rubicon that divides the approved from the rejected." To this great army, we think, Dr. Cow's book should be of considerable service.

Pass List.

Society of Apothecaries of London.

June, 1920.

The following candidates passed in:—

Surgery.—A. Mackenzie.

Medicine.—W. H. Summerskill (Section 1).

Forensic Medicine.—W. H. Summerskill.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES, PART II., July, 1920.

G. R. M. Apsey.	S. C. Bakhle.
L. Fogelman.	N. W. MacKeith.
C. A. Probert.	S. H. Robinson.
G. D. Shaw.	T. A. Shaw.
*W. R. Spurrell.	G. M. Stoker.
E. C. Warner.	H. J. Westlake.

J. L. Woodhouse.

*Distinguished in Anatomy.

Births.

CHAPPLE.—On June 19th, at 18, Devonshire Street, W.1., the wife of H. Chapple, M.A., M.C., F.R.C.S., a son.

HARDY.—On June 29th, Eva, wife of G. Frank Hardy, M.C., M.R.C.S., L.R.C.P., of Highlands, Champion Hill, S.E., a daughter.

MAXTED.—On June 29th, at 14, Thorpe Mansions. Norwich, the wife of G. Maxted, M.D., B.S., F.R.C.S., a son.

RYLE.—On July 21st, at the Warden's House, Guy's Hospital, to John and Miriam Ryle, a daughter.

Deaths.

HOBY.—On June 12th, at Boston, U.S.A., Kenneth G. Hoby, L.D.S. (Eng.), on his way from New Zealand to England.

SCOTT.—On July 18th, at 2, Queen's Gardens, Osborne Road, Windsor, William Jerman Scott, M.B., B.S.

ED.—M. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

READERS of the GAZETTE may remember in a recent issue a pathetic letter from "Mater Familias" complaining of the hard way in which her offspring was treated when on duty in the Front Surgery. Certainly men who have dressed in the Front Surgery both under the old system and under the one that was introduced at the beginning of this year are unanimous in condemning the latter, and we do not think that a tour of duty introducing such work as falls to the lot of a Front Surgery Dresser, of 9½ hours can easily be defended. Now, after six months of complaint, the authorities have apparently evolved a new system, they have reverted to the old division of the day into three shifts (*i.e.*, from 9.30 to 1, 1 to 7, and 7 to 11), but instead of two dressers sharing each shift there is now, it appears, to be only one. We have no hesitation in saying that this is not a happy solution of a problem which certainly presents considerable difficulties. Dressers are scarce and economies may be necessary, but has the author of the new scheme ever been in the surgery on a Monday morning? If he has, he must realise that one Dresser is completely and hopelessly inadequate to deal with the accumulation of patients that collects by mid-day unless some steps are taken to keep out all but urgent cases—which is practically impossible. If the shortage of men competent to "run the Front" is really so serious we should have thought that a wiser economy would have been to put two men on for the first shift and one for each of the other times. The afternoons are sometimes (but not always) slack—the mornings never. We hope that some suitable alternative to the present state of affairs may be found, and, while we are on the subject of the Front Surgery, we would urge that the list of dressers for the week be posted earlier than on Wednesday afternoon and that, whenever possible, it should be sufficiently accurate to avoid the necessity of a new one having to be posted the next day.

Dr. CAMERON has resigned his position as Assistant Physician to the Hospital. We are sorry that a teacher of his capacity will no longer be heard in the general wards, but the importance of his work and teaching on Children's Diseases justifies his resignation of a post which left him too little time for his special subject. The importance of Pediatrics was referred to in our last issue in "Passim," and with Dr. Cameron able to devote his whole time to this important branch of medicine, we hope

that great benefit to Guy's students will result. When the new Baby Ward is built, Guy's men will have unrivalled opportunities of studying the Diseases of Children under the direction of one well qualified for the task. To complete our Baby Department we should like to see a Registrar appointed, for more teaching on Diseases of Children is of vital importance and will not become less so as time progresses and our accommodation in cots increases.

The vacancy caused by the resignation of Dr. Cameron from the ranks of the Assistant Physicians has been filled by the appointment of Dr. Marshall. We offer him our hearty congratulations.

THERE has for a long time been difficulty in obtaining Anæsthetists for the Assistant Surgeons. At present the arrangements are left in the hands of the A.H.S. concerned, with the usual result that, after a lengthy and fruitless search for a victim, he is left to administer the anæsthetic himself. In consequence the A.H.S., at the end of his appointment, finds that he has given anæsthetics more times than he has assisted at operations. Surely it is important that the house officer who is in charge of the case should be free to see all that happens while the case is in the Theatre. With a little organisation it ought to be possible to allot definite anæsthetists—not necessarily Staff Anæsthetists—to Assistant Surgeons on their official operating afternoons.

THE discussion in the public press of the relative advantages of the different sites for the Headquarters of the University of London has probably strengthened the hands of the anti-Bloomsbury party on the Senate, and led to the temporary rejection of the Government's offer of a vacant space behind the British Museum. Further consideration of the terms of the Government's offer is, no doubt, desirable, but the Senate will not be materially helped in their decision by the descriptions of the rural joys and architectural glories of Kenwood or of the commanding appearance that could be given to a building on the Surrey bank of the Thames next door to the offices of the L.C.C.

The supporters of sites other than Bloomsbury hardly recognise, perhaps, the necessity of placating certain rival vested interests which have hitherto proved insuperable in securing agreement upon a site, and some of the arguments put forward in favour, say, of Hampstead Heath, indicate that the requirements of a College rather than of administrative offices have been in the writers' minds.

The University of London has long suffered from the local patriotism of its constituent colleges, and in choosing a site for its central offices regard must be had to the fears that certain sites may give an undue advantage to one or other of these rival institutions.

The Government is, no doubt, well aware of these difficulties, and has probably done its best to overcome them in the conditions which it proposes in connection with the Bloomsbury site. The Medical Schools have all to gain and nothing to lose by the establishment of accessible and adequate central administrative offices which would form a focus for University, as distinct from College, activities. The present offices in South Kensington are neither adequate nor accessible, and the medical students and the faculty of medicine of the University will watch with hopeful interest the attempt to find a suitable alternative. A League of Schools of the University of London is almost as necessary as a League of Nations.

DURING the last fortnight two more cups have been added to the already overburdened glass case in the College Smoking Room. The Swimming and Water Polo Cup was, rather unfortunately, a walk-over (or swim-over, if

that is the right expression), as Middlesex, the other finalists, were unable to raise a side. On Saturday last the recently-revived Boat Club marked its resuscitation in no uncertain fashion by winning the Inter-Hospital Rowing Cup from Bart.'s, the holders. It must be many years since a crew from this Hospital competed for this trophy, which was founded in 1885, and an exhaustive search amongst the names of the winning crews inscribed upon the Cup compel us to admit that we have never won it before. But if this reflects sadly upon athletes of past generations it will be a matter of considerable satisfaction to those who have supported and assisted in the re-organisation of a club which, as letters which appear elsewhere in this issue will testify, was once a flourishing concern.

The successes of the present year must be almost unparalleled in the athletic history of the Hospital, and we hope to be able to publish in our next issue a complete list of all the Inter-Hospital events for the past season, with the results. To crown a victorious year, which will ever be a source of pleasant reminiscence to present Guy's athletes and which those whose efforts upheld our great tradition in the past will look upon with pride and satisfaction, comes the news that L. G. Housden has been selected to represent England in the Olympic Marathon at Antwerp. Stewart, of the London Hospital, represented England in the last Olympic Games at Stockholm in 1912, and it would be interesting to know how many times in the past history of the Games such a distinction has fallen to the lot of a hospital athlete. Guy's men, past and present, will join with us in offering our congratulations to one who, as captain of this year's team that won the Inter-Hospital Athletic Shield, has contributed in so distinguished a manner to the athletic record of the past year.

There has recently been talk of raising the Clubs' Union Annual Subscription from three to five guineas. At a time like this when prices for everything are steadily increasing, the fact that the Clubs' Union finds itself unable to fulfil its financial engagements on pre-war income will surprise no one. But it will inevitably be argued that, considering the very large increase in the number of students, the annual income of the Clubs' Union must be considerably more than it was six years ago; and further, that the increase in number of students does not entail a commensurate increase of expenditure. These facts are both probably true. But many of our readers may be surprised to learn that during the year 1919—20 some 200 students have paid no Clubs' Union subscription at all. Theoretically this is all very well. It is not a compulsory subscription, and a student may remain outside the organisation entirely. Yet it is hardly conceivable that all of those 200 students have refrained from indulging in any of the privileges of a member of the Clubs' Union; for it must be remembered that a man who has not paid his annual subscription is, amongst other things, not entitled to enter any of the Club Rooms in the College, nor has he any right to make use of the ground at Honor Oak Park or to attend meetings of the Physical Society. At present there is no safeguard against students whose morals are sufficiently lax to allow them to make use of privileges to which they have no right and for which they have not paid. We understand that, if the subscription is raised, steps will be taken to ensure that the rights of membership are not abused. But at the same time we think it might be worth the while of the Clubs' Union Committee to consider the question of instituting individual subscriptions to individual clubs. Other Clubs' Unions of which we have had intimate knowledge adopted this method with good results. It prevents a hardship being inflicted on men who really cannot afford the full subscription but who wish to avail themselves of the use of the Students' Club, while it is found that all men who play games will pay the full amount to enable them to indulge in any sport to which they take a fancy. At present it is all or nothing, and apparently with a large proportion it is nothing.

Some Mechanical Considerations in the Surgery of the Leg.

CLINICAL LECTURE BY W. H. TRETHOWAN.

(*Continued.*)

[In the first half of this article, which appeared in the last number of the GAZETTE, a general account was given of the disabling effects of deformity due to malunited fractures, and in greater detail the mode of production, mechanics and treatment of the various fractures in the vicinity of the ankle joint and in the lower part of the leg.]

When dealing with an abduction or eversion fracture of the tibial shaft, it is advisable, as far as it is possible, to divide the malunion at the original site of fracture. An ordinary transverse osteotomy will permit the restoration of the horizontal axis of the ankle joint by swinging the foot and leg below well in, but this is liable to give a tibia which looks unpleasantly bowed at the completion of the operation. The question of the means of fixation to be adopted after section of the bone is a matter of taste, and can be by plaster of Paris, metal plate, ivory pegs, or a bone graft slid from the longer fragment or taken from the opposite tibia. Personally I consider that autogenous bone grafts, or perhaps sterilised bone, will substitute plating as a fixation means. I will show you in a subsequent lecture numerous examples of bone grafting methods. There is no doubt in my own mind, that, however rigidly a plate be fixed, and however careful the technique, the existence of a metal plate and screws does delay union of a fracture in many cases. There appear to me very few indications for the general use of metal plates as a routine treatment for internal fixation of bone fragments, and the advantage is undoubtedly with grafting for general use. Where a great strain must be taken, as in a bad overlapping old fracture of the tibia, or where a heavy segment of the limb has to be fixed, as in precise correction in the upper part of the femur, plates will continue to be of the greatest service; but in some of these cases, where the question of restoring the length of a bone is important, it may, on account of the contracture of the soft parts, be desirable to perform the osteotomy at the first stage, and by a later operation internally fix the fragments and make the correction precise, after the soft parts have gradually been lengthened by traction on the limb for two or three weeks.

An interesting type of deformity due to injury in the region of the ankle joint is occasionally seen in children, and results from damage to the epiphyseal cartilage of the lower end of the tibia; in this condition the fibula continues to grow in length while the tibia does not, and consequently the foot is gradually thrust round into an inverted or adducted position, and the weight borne on its outer side. In such a case we use an inside steel, but otherwise leave the deformity uncorrected as long as possible if the child be still growing, and then, when it must be done, an osteotomy of the fibula and tibia is performed just above the malleoli: a small piece is taken out of the fibula and transferred to the tibia to restore its length. Other types of deformity of the tibia which I now show you, some resulting from fracture and some from rickets and other bone disease, are those in which the bone is bowed either too much backward or too much outwards. Angular deformity convex backwards, just as in those similar cases of the femur which I shall show you presently, produce a backward displacement of the knee, or genu recurvatum. The knee joint, like the ankle joint, can be forced into a false position, and thus be subject to traumatic arthritis. As the body weight now falls in front of the joint, the knee tends more and more to hyperextension, with consequent stretching of the posterior capsule and the crucial ligaments. The infra-patellar pad of fat and the ligamenta mucosa become pinched, congested and swollen and the patient complains of pain on either side of the patellar ligament. It is not uncommon to find associated with the backward bowing of the tibia, especially if the deformity be in the upper part of the bone, some considerable adduction and internal rotation of the leg and foot below the site of the fracture, and to the disability of the knee is added that of the foot and ankle. Correction of this backward bowing is easily done either by linear osteotomy of the tibia, or by cutting out a wedge of bone and reversing it; as the wedge can be cut accordingly, the method lends itself to the correction of a deformity in one or more planes. The operation of the "reversed wedge" is a very simple and satisfactory one, and can be applied whenever the bone section is done in the immediate vicinity of a joint, because of the increased sectional area of the bone at its extremity; the angle of the wedge should be half that of the

angle of the deformity, and the subsequent fixation should be by plaster of Paris. It may at times be inexpedient or impossible to cut the bone at the actual site of the deformity, as, for example, in a case of gunshot wound of the tibia which I now show you. Here the poorness and thinness of the bone at the site of the original fracture, and the liability to recrudescence of the original septic infection, led us to do the osteotomy an inch or two above, where the bone was perfectly normal; this is the method of the "compensating osteotomy," another example of which is seen in the division of the shaft of the femur at its middle when we wish to correct the external rotation associated with coxa vara. A curved deformity of the tibia outwards, or bow leg, is an exaggeration of the normal shape of the bone, and in order to keep the sole flat on the ground there may be a compensating abduction deformity at the sub-astragaloid joint, giving strain and pain at the inner side of the foot and ankle joint. In such a case, merely relieving the foot by wedging the boot on the inner side of sole and heel tends to increase the deformity of the tibia, and also produce pain and arthritis in the knee, and for these two reasons osteotomy may be desirable. This operation is best done by the transverse section, with fixation either by a sliding graft or in Plaster of Paris. In children with ricketty tibiæ we avoid osteotomy in the lower part of the bone whenever possible, as such cases are notoriously liable to non-union.

I would like now to show you some cases of fractures involving the knee-joint itself. The first is the case of a man the internal tuberosity of whose tibia was crushed down and impacted into the remainder of the head of the bone, the articular surface of the tuberosity being lowered by about three-quarters of an inch. He was thus left for three months or so, and when he got about again the inevitable result was a marked bowed leg. Now it would have been quite easy for his surgeon at the time of the injury to raise the tuberosity and the articular surface into its normal position by means of a broad chisel, and this is what we were subsequently compelled to do. The gap thus left in the lower part of the internal tuberosity of the tibia we filled with a short piece of bone of the same width taken from his tibia lower down. The graft was assimilated into the structure of tuberosity, the wound healed perfectly, and the leg was thus easily straightened; the ultimate function of the knee-joint was very good indeed. In another case where the tuberosities of tibia were split apart and one impacted into the other, with derangement of the articular surface, the surgeon screwed the fragments together in the deformed position. The patient came under my care some time later at out-patients, with the knee-joint so much impaired in movement, that we could do very little, but I have often wished that I had raised his tuberosity to a normal level as described in the first case. Next we see two cases of fracture of the lower end of the femur. In the one the internal condyle is separated by a long vertical fissure, and is displaced up about half-an-inch or more from the external condyle, which, you see, has resulted in a bowed leg. In a simple fracture this fragment should have been replaced and fixed by a bone peg immediately after the injury, for I maintain that the alternative and subsequent course by osteotomy, while straightening the leg, could never restore the efficiency of the knee-joint. The other case is a more or less transverse fracture of the lower end of the femur at the level of the margin of the articular surface, and, as is so often the case in this injury, the condyle had slipped round to a position somewhat behind the upper fragment. Such a case came for treatment on account of a seemingly fixed flexion deformity of the knee-joint of about 45 degrees. It is only on close examination you realize that the knee-joint is really perfectly straight and quite extended, although it appears to be flexed. The only thing you could do to this would be an osteotomy at the site of the old fracture, and while correction of the deformity would be easy, I am afraid we should not get much return of mobility in the joint. Such a case could easily have been corrected by open operation at the time of the injury, or probably as easily corrected merely by manipulation and plaster, as fractures in the vicinity of the larger joints are not always difficult to reduce, and maintain, when the correction has been made. In cases of long standing genu valgum or knock knee, especially in those where both bones are deformed as the result of rickets, in view of the importance of keeping the axis of the knee-joint quite level, it is often better surgery to osteotomise the bones both above and below the joint, and procure some correction at each spot, rather than obtain the whole correction in the femur as is usually done in the Macewen osteotomy.

Turning our attention now to the shaft of the femur, the deformity commonly occurring about its middle and in its lower half is an angulation backwards, with end to end apposition of the

fragments. It gives a similar general appearance to the leg, and causes the same mal-effect on the knee joint, as that described above, resulting from a similar deformity of the tibia. The fixation after correction of the bone may be either by means of a metal plate, or by the flexion position in a Thomas's knee splint; in the latter method the angulation backwards can be converted into one forwards by suitable suspensory bandages behind the thigh. In some cases the principal element of deformity in a fracture in the lower half of the femur is merely overlapping of fragments, and shortening of the limb without other change in the alignment. Whether one should operate in an old case of mal-union merely to correct shortening, which otherwise could be compensated for by a boot, is a point which must be decided after careful consideration of the age of the deformity, the proximity of the lesion to the knee joint and its effect on the function of the joint, and of the age of the patient. No dire mechanical effects are likely to happen to a limb which is merely short, and the length of which is restored by a compensating boot. In the upper half of the shaft of the femur the common deformity is, as you know, an angulation or bowing outwards, associated with perhaps internal rotation and adduction of all the limb below; overlapping may or may not occur. In any case this deformity may require correction both to restore loss of length of the limb due to the angulation and to give an increased abduction range of movement to the hip joint. In long standing cases such a deformity may be most difficult to correct, especially if one wishes to restore the length of the bone. The powerful adductor muscles on the inner side of the thigh are firmly contracted and strongly resist efforts to restore the alignment after the bone section has been made. If internal retention is not secured by means of a metal plate there is a great tendency for the upper end of the lower fragment to slip to the inner side of the upper, thus correcting the angulation, at the expense of increase of shortening. Preliminary tenotomy of the adductor muscles will assist, but will not give all the help that is desired. In the case I show you now, which has four inches of overlapping, although we were able to bring the fragments end to end we had to leave the femur somewhat bent still as you will see in the picture. These higher fractures of the femur exercise a pernicious effect on the hip joint. The persistent abduction of the upper fragment permanently raises the great trochanter and shortens the glutei muscles, and brings the head of the femur into an extreme relationship with the acetabulum. One case of fracture of the femur about four or five inches below the trochanter, with angulation outwards and abduction of the upper fragment, which had thus existed for about ten years, recently began to complain of pain and stiffness in the hip joint, due to the repeated trauma and arthritis set up by continued use of the hip joint in the strained position of abduction. We estimated the angle of his deformity, and, having bent a metal plate to the proper angle of correction, we attached the plate above the line of the proposed bone section; then the bone was cut through, and the lower fragment brought out to meet the plate. Such a procedure threw the whole leg into extreme abduction, and when the patient resumed walking he brought the limb gradually into the proper position, thus gradually stretching the short glutei muscles, and bringing the head of the femur into a new and fair relationship with the acetabulum.

Deformity of the neck of the femur as in coxa vara, partial subluxation of the hip joint with the inevitable flexion deformity, and anchylosis of the joint with deformity, are best treated by transtrochanteric osteotomy, or by osteotomy of the shaft just below the trochanters, according to the need of the case. When the movement of the hip joint is to be preserved it is better not to divide the neck of the bone. As a rule osteotomy of the femur is avoided in cases of progressive deformity when the joint is not quite anchylosed—for example, in the later stage of tuberculous disease, on account of the fear of recurrence of the deformity and the consequent uselessness of the operation. But often the deformity is not progressive, and then the operation can be done with confidence. When flexion and adduction deformity exist the compensating lordosis of the spine and the raising of the pelvis on the same side cause fatigue and backache. A metal plate may be bent in one or more planes according to the correction required and applied after section of the bone an inch or two below the trochanter, and thus the correction precisely determined. Rotation deformity of the limb at the hip joint is best corrected by osteotomy of the femoral shaft about its mid point, where it is most easily accessible, the fixation being maintained by an intramedullary bone graft or peg together with a plaster spica.

. When arthritis of the hip joint is well marked no adjacent bone section can have

much beneficial effect. It is then a question of the treatment of the joint itself, which will depend on what element of the disability is most troublesome, and on the particular desire of the patient. A little painful movement in the hip joint is worse than useless, and a completely anchylosed hip without pain is preferable. The anchylosis can be brought about either by an internal operation to destroy what remains of the joint surfaces or by fixing the joint from three to six months in a plaster of Paris spica. But a completely fixed hip joint is to a helpless patient a very serious disability, on account of the difficulty of sitting properly, and even more so because of the impossibility of putting on his own shoe. When pain is troublesome, but retention of mobility is desired, the older operation of complete excision of head of the femur, with retention of the leg in an abducted position for some months in plaster of Paris, to drive what remains of the neck into the acetabulum, is an operation which is favoured by some. The operation certainly relieves the pain, but the subsequent instability of the joint is a factor to be reckoned with. When it is considered that a certain period of rest, or rather release from weight bearing, would result both in diminution of the pain and restoration of mobility, the treatment adopted would be by means of an ambulatory weight relieving appliance, such as the simpler "Calliper splint" or the more complicated "Hessing appliance." This splint or "extension" treatment may be very tedious to older subjects. There remains to be mentioned the operation of arthroplasty, as devised by Murphy, which is really a kind of modified excision, with care taken to leave as much as possible of the head of the femur. After the anchylosis has been cut through in the original line of the joint and the head of the femur rounded off nicely and the acetabulum hollowed out, a double flap of fascia lata is made to clothe the head of the bone and line the acetabulum. Access to the joint is afforded by cutting off the great trochanter with its attached muscles through an external skin incision, and refixing it subsequently by a screw or peg. The joint is immobilized and extension applied for several weeks, after which the patient gets about for some months in a weight-relieving appliance, and physiotherapeutic measures are utilized to improve the movement of the newly formed joint. It is too early yet to speak with any degree of confidence of the results of this operation for forming a new hip joint.

Appointments.

W. S. Russell Thomas, B.A., M.B., B.Ch. (Cantab.), M.R.C.S., L.R.C.P., to be Assistant Medical Officer to the West Riding Asylum, Wakefield, Yorkshire.

A. W. Sheen, C.B.E., M.S. Lond., F.R.C.S., Visiting Surgeon (for general surgery) to Ministry of Pensions Hospitals, Orpington and Shepherds Bush.

Lancelot Bromley, M.Ch., F.R.C.S., Surgeon to the Neurological Department, Guy's Hospital.

The following gentlemen have been appointed by the Treasurer as "Operators" for the ensuing year: Mr. F. Cook, F.R.C.S.; Mr. J. Joffe, F.R.C.S.; Mr. W. H. Ogilvie, F.R.C.S.; Mr. W. E. Tanner, F.R.C.S.

July 23rd, 1920.

Extract from *Northern Rhodesia Government Gazette* of 28th June, 1920:

Government Notice No. 68 of 1920.

It is hereby notified for public information that His Honour the Administrator has been pleased to appoint Percy Harold Ward, Esquire, M.R.C.S., L.R.C.P., to act as Principal Medical Officer for Northern Rhodesia from the 8th of June, 1920, until further notice.

By command of His Honour the Administrator,

RICHARD GOODE, *Sec.*

Pass List.

University of London.

M.S. EXAMINATION, JULY, 1920.

Surgery.

G. T. Mullally, M.B., B.S., F.R.C.S.

M.D. EXAMINATION, JULY, 1920.

Medicine.

T. I. Bennett, B.S. F. V. Bevan Brown, B.S.
*Geoffrey Marshall, B.S.

State Medicine.

*Hugh Stott, B.S.

*Awarded University Medal.

Change of Address.

Dr. A. Withers Green, Honorary Secretary, Poor Law Medical Officers' Association, from Wardrobe Place, E.C.4., to 114, St. James' Terrace, Warwick Crescent, W.2. Official address: 34, Copthall Avenue, E.C.

A. D. Marston, from 45, Queen Anne Street, W.1., to 7, Portland Place, W.1. (Telephone: Mayfair 5019).

Infant Welfare Centres

(From a Non-Medical Correspondent).

AT the present time new Infant Welfare Centres are being established all over the country. It is, therefore, of the utmost importance that their true function should be understood so that further developments may follow the right line. Equally important is it that this movement should receive the sympathy and support of the medical profession generally. The Editor has invited me to express my views on infant welfare work, views which are the outcome of many years of practical experience as a helper. This I willing do, in the hope that a discussion of this important subject may take place in the GAZETTE.

This movement is comparatively young, and is the inevitable sequence to the system of medical inspection instituted in the elementary schools some years ago. Statistics show that most babies are born quite healthy, yet by the time that they come under the care of the school medical officer, a large proportion is found to be suffering from various physical disabilities, many of them being preventible. The starting point of the evil, therefore, occurs before school days when the well-being of the child largely depends upon the mother. In some cases she may be careless or indifferent, faults of character which inevitably re-act unfavourably on her children. Far more commonly, however, a mistaken kindness, the result of ignorance, aggravated by the unsatisfactory conditions in which town workers especially are compelled to live, is the root of the trouble. In order to keep her baby healthy the mother must understand her job. A few misguided people still uphold the view that a woman knows by instinct how best to bring up a family, but most of us now realise that mothercraft is a skilled calling, of national importance, needing education and training as much as other technical pursuits. This need for training is more obvious among the poor than among the rich, but education in childhood's problems is quite as much required by the well-to-do, many of whom are inclined to fuss unduly over their offspring. At the moment the problem of the working-class mother is the more urgent, and it is for her that the Infant Welfare Centre primarily exists, and it exists or should do so as a place for education. Here mothers can bring their babies regularly, have them weighed and inspected, and learn from a properly qualified teacher how to keep them healthy and to bring them up to be useful citizens.

There are usually two branches of the Infant Welfare Centre's work. The first is called, for want of a better word, the infant consultation or clinic. It is unfortunate that terms have been chosen which already have associations with disease. The atmosphere of an infant welfare centre should be one of health; its motto should be "Prevention is better than cure." It is true that a medical practitioner presides over the "consultation," but he should do so more in the capacity of a teacher than in that of a curer of disease. The mother is taught on a living model—her own child, and this excites her interest and enables her to grasp the instruction as no other method could do. The educational side of the work should be insisted upon from the beginning and mothers must be taught to discriminate between such work and that carried on at a hospital. This educational work cannot be done in a hurry and is not easy. The medical officer must have plenty of time to talk to the mother, to explain to her in simple language that she can understand, the reason for the advice given, to endeavour to look at things from the mother's point of veiw and to realise the difficulties and limitations of her home conditions. The mother herself has to be sized up, as sometimes it is found that the trouble with the baby is due to a psychological defect in the mother. The medical officer must take every opportunity of gaining the mother's confidence and so strengthening her to stand firm against the well-meant but mistaken kindness of endless relations and friends, each of whom will urge her own special scheme for keeping baby healthy. These duties demand tact, adaptability, patience and common sense on the part of the medical officer. To deal adequately with all these problems, it is clear that plenty of time must be allowed, and the medical officer should not be asked to see more than about twenty-five mothers during one session. A useful adjunct is a small notebook given to each mother in which the principal instructions are written clearly and in detail by one of the assistants. This the mother takes home with her and is able to study at her leisure. Diet, clothing, sleep, exercise, hygiene, the inculcation of good habits, moral training are all legitimate fields for the in-

struction. No attempt should be made to treat diseases, with the sole exception of quite minor defects and this by way of teaching the mother how to cope with the small emergencies which will arise in the healthiest babies. To learn to deal with such things is part of every mother's necessary training. She should be taught to recognise danger signals and to realise when the help of a medical man should be secured.

An essential part of the consultation is a trained salaried Health Visitor. Her duties are to attend the consultations and become familiar with the instructions given to the mother. Armed with this knowledge she makes periodic visits to the mother in her home, learns the special difficulties of her environment, goes over with her the instructions in her note book and helps in every way to get them properly carried out. The Health Visitor also looks up those mothers who are irregular in attendance, and tries to persuade them to come more often.

The second branch of the Welfare Centre's work is carried out by means of classes and simple talks on hygiene, the management of children, home nursing, cooking, etc. These classes can be given by voluntary or paid workers, and must take place on a different day from that on which the clinic is held. During the classes children under school age must be amused in a separate room; the mothers cannot leave them at home, as a rule, and if they are admitted to the classroom serious work becomes impossible. Needlework and cutting-out classes are generally very popular, and advice as to the best type of garments can then be given. Teaching the mothers to sew and cut out is far more valuable than selling them garments at or under cost price, a policy which is adopted at many centres. These doles are a temporary benefit only, whereas if a mother has learnt how to make a garment herself she is for ever independent of outside aid in that particular respect.

These are the broad lines on which an Infant Welfare Centre should be run. There is grave danger if these principles are neglected that these places may develop into inferior infant out-patient departments, ursurping the functions of hospitals and general practitioners and neglecting their own specific duty, which is education. To avoid this, better facilities for treating disease among the babies are urgently needed. These facilities must be provided elsewhere than at the Centre. At the present time, when the baby falls ill, all that is possible is to refer the mother to her doctor or to a hospital. In the first case she is often deterred from following the advice by the thought of the fee; in the second, by the expenditure of time involved in travelling or waiting. Could not some voluntary system of insurance for those attending the Centre be established so that they could, when ill, be referred to their own medical attendant, who in his turn would refer them to the suitable hospital or other institution should more complicated treatment be required than he is able or willing to give? There are surely obvious advantages in such a scheme. The baby having his minor ailments dealt with by the Centre would only be sent to the doctor when there was something definitely wrong. A report from the Centre should be sent up with the baby. It would clearly be to the doctor's advantage to persuade all the mothers to go to the Centre and learn there how to avoid those mistakes which bring disease in their train. The Centre would have no excuse for carrying out treatment if each mother had a doctor to whom she could be sent. The financial side of the scheme would be difficult, but surely not insuperable. The medical profession has in the past organised successful provident systems for treatment on a capitation basis. The payment of the doctors by a constant weekly contribution would be one essential of the scheme, and others that any medical man who desired to join could do so, and that the mother should be able to choose her own doctor and to change him under certain necessary restrictions. It might be possible to arrange that the mother's weekly payments could be made at the Centre. In the absence of some such provision the temptation to undertake treatment at the Centre can hardly be resisted.

Papers by Guy's Men.

J. Macdonald Gill, M.D. On Heart Irregularities.—*Medical Journal of Australia*, June 5th, 1920, p.526.

Arthur F. Hurst, M.A., M.D. Oxon., F.R.C.P. The Croonian Lectures on the Psychology of the Special Senses and their Functional Disorders, delivered before the Royal College of Physicians of London, June, 1920. Lecture 1: Cutaneous Sensibility and Cutaneous Anæsthesia (illus.).—*Lancet*, cxcix., July 24th, 1920, p. 169.

J. F. W. Silk, M.D. A modification of the open Ether Method.—*American Journal of Surgery*, Vol. xxxiv., July, 1920, p. 82.

Inoculation.

As every one knows, prophylactic vaccines played an important part in the war in controlling the incidence of certain diseases, especially those of the enteric group. Their value has been disputed by some authorities, and among the latter are several prominent members of the Indian Medical Service, who claim that the much-quoted statistics produced by the Indian Government in the last ten years are untrustworthy. They believe that the reduced incidence of enteric fever among the troops in India and the low incidence during the war are due, not to vaccines, but to improved sanitation. This view is not accepted by the majority of people, who are convinced of the efficacy of preventive vaccines. In addition to the better known T.A.B. vaccine, anti-cholera, anti-plague, anti-dysenteric, and anti-influenzal vaccines have been used in the different theatres of war in which the particular disease was endemic. Two features appear to one to be noteworthy in regard to the use of vaccines in the Army, namely, the almost complete freedom from serious catastrophes and the willingness of the vast majority of men to submit to having a mysterious fluid injected under their skin. In regard to the second point, it is well known that propaganda was carried on against inoculation, partly by ignorant but honest people, partly by enemy agents, and various popular ideas were in vogue as to the evil effects of vaccines "on the system." The most prevalent idea, and the one that frightened Mr. Tommy most, was that inoculation would render him impotent. But, in spite of all this, I believe more than 90 per cent. of men submitted to inoculation.

In regard to the first point, T.A.B. vaccine was manufactured in vast quantity hurriedly by people many of whom, in the first few months of the war, were necessarily unskilled in the technique of production. Again, the vaccine was given to millions of men, often in most septic circumstances, and in a few cases, I am afraid, by careless or incompetent medical officers, and yet very few cases of any untoward happenings are known of. The ordinary reaction to the vaccine varied in individual severity, and, in some susceptible people, caused high fever for a few days. But this reaction is to be expected, and is more or less desirable. But to have succeeded in giving to millions of men a fluid the chemical nature of which is not known, in all sorts of conditions and circumstances, and with so few accidents, is, I think, very remarkable. The following is an account of what I believe is the only serious calamity resulting from the use of vaccines. In it seven men died and sixty were rendered more or less seriously ill as a direct result of inoculation with anti-cholera vaccine.. The unfortunate affair occurred during the war on a Government transport conveying troops across a tropical ocean. There were 4,500 men on board the ship, which had been constructed to carry a maximum of 3,000 men in cold latitudes. The ventilation of the lower decks was almost nil, the fresh water supply was very limited, the washing arrangements only permitted a man to get a wash on an average once in four days in salt water, the bunks and hammocks were lousy, the food was only good in parts, and the general conditions in the extreme heat were so bad that existence was misery, and the unfortunate men were in a state of mind varying between mutiny and despair. The medical arrangements were not very good. There were 20 orderlies and five medical officers, including an S.M.O., who was imbued with the true Army spirit of economy and considered that 3 lbs. of boric lint were sufficient for 4,500 men for 17 days; other drugs and dressings were in proportion. The hospital was of the ordinary type on a transport, adequate for a few mild cases of illness but a very awkward place in which to deal with a rush of serious cases.

In accordance with shore instructions, inoculation with anti-cholera vaccine was commenced on the third day out. The vaccine used had been made up in the country we had just left. Owing to the bad conditions prevailing on the ship, the technique used in administering the vaccine was more than ordinarily careful. About a hundred men a day were given their first dose of ·5 cc's into the upper arm. The normal reaction was observed in the first 48 hours, but the local swelling, instead of subsiding at the end of this time, persisted, and on the 6th or 7th day began to increase in size. Men were encouraged to report sick if their arms were not normal, and there were large daily sick parades of men all complaining of swollen arms. Many of these men were found to have temperatures ranging up to 102° F., and all such were admitted to the hospital, which was soon full. The less serious cases were given slings for their arms, and were sent up on deck to lie down in the shade.

In the majority of cases the swelling was limited to the upper arm. The centre of it was brawny, with a wide zone surrounding it of soft œdema. There was no pain, and the patient felt seedy but not definitely ill. In about twenty cases the swelling spread rapidly up and down the arm, the central part hard and the outer zone soft, until in some cases the whole arm and hand and shoulder were brawny hard. The skin was œdematous but always white, never red or inflammatory; there was never any evidence of pus formation, no involvement of lymphatic glands. Sometimes the brawny swelling invaded the chest wall. The general condition of the patient was remarkable. He was quite free from pain, and often said he felt quite

well except for a headache. However, he did not look well; he sweated and became pallid. The temperature swung up and down between 104° and 100°, and in a few hours or a day or two the pulse began to mount. In the fatal cases the picture was typically that of profound shock. The extremities became icy cold in spite of the tropical atmospheric temperature, the skin was pale and clammy, and the pulse rapid and thready. The pupils were dilated, and the patient tended to become restless, but his mentality remained clear. Death in the end came suddenly. In the cases that recovered the swelling, after reaching a maximum, slowly subsided. Cold extremities and a pulse-rate above 110 were invariably fatal signs.

Owing to the circumstances we were unable to investigate the cases in any detail. It is clear that data such as blood counts, blood cultures, cultures from incisions in the arms, etc., would have been highly instructive. We were able only to observe the clinical signs and the course of the disease.

Our treatment was distressingly handicapped by lack of, or absence of, dressings, instruments and drugs. In a very short time we used up every thing, except morphia, which was of little use, and for dressings to the arms we had to tear up sheets and blankets and wring them out of boiling salt water. We gave as much fluid by the mouth as possible, and also by the rectum, but we had no means of giving saline infusion or transfusion. We incised some of the arms to relieve the tension of the tissues, but with no apparent benefit, and with the risk of introducing sepsis. The incised tissues were dark red and œdematous and exuded a little clear fluid. There was never any sign of pus. We considered amputation through the shoulder, but under the circumstances decided against it.

I should have mentioned that we quickly discontinued the inoculations when we saw what was happening, but not before we had discovered one important point. The vaccine had been made up in two sets of bottles, some large and some small. They had been made at the same laboratory, were of the same date (a recent one), *but only those men who had received vaccine from the small bottles developed symptoms.* We carefully preserved what was left of both sets of vaccine for future investigation. The technique employed was the same when inoculating from large or small bottles.

I think there can be no question of anaphylaxis as an explanation of the condition. The men in all cases were receiving a first dose, and the symptoms in many respects differed from those of anaphylactic shock.

On arrival at our destination the sixty odd cases of men with bad arms were sent to the local hospital, the vaccine was sealed and conveyed to a bacteriologist, and a Board of Enquiry was convened to examine the facts of the case. After a very exhaustive examination the conclusion come to by the Board was indefinite, but the whole matter was conducted rather secretly, and it was difficult to find out details. The bacteriologist found an organism in the vaccine from the small bottles, but was not sure of its nature or whether it was pathogenic or not. The investigations on the cases taken to the shore hospital were also inconclusive.

There is an interesting sequel to record. The bacteriologist who made the vaccines wrote the following report a year later, as far as I know without reference to, or knowledge of, the affair I have just described:—

"I beg to report that this is the third occasion on which I have complained of the condition of my Laboratory, which is not dust-proof. Until it is rendered dust-proof I cannot be responsible for any sera or vaccines made in it."

It would be interesting to hear the opinions of readers of the GAZETTE as to the pathology of the condition I have described above.

F. V. BEVAN BROWN, M.D.

A Case of Stokes Adams Disease.

W.P., aged 64, was admitted into Addison on July 28th, 1920, for dyspnœa. He is a gardener, and has followed his occupation until the onset of his dyspnœa three weeks ago. His past history and habits are good except that some years ago he fell and cut his head. Since then he feels giddy and may fall if he turns round suddenly. The onset was quite sudden, and occurred while he was at work. Since then he has been unable to commit the smallest amount of exertion without severe attacks of gasping. His wife says he sleeps well in any position, and that she has noticed that when asleep his breathing has a markedly rhythmic character, being almost imperceptible at times and then increasing in force only to die away again a short time after. He has complained during the last fortnight of a severe "cutting" pain over the lower part of his chest which is fairly constant and localised to the left front, side and back.

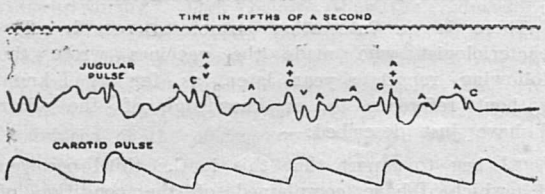
Physical examination shows a well covered healthy looking man with obvious respiratory distress. His breathing when in bed is of a typical Cheyne Stokes type and he speaks in gasps. There is, however, no cyanosis. His pulse is very slow (from 30 to 35) but quite regular. He possesses a blood pressure of 225mm. systolic and 18mm. diastolic. The heart is not enlarged, and there are no bruits. The timing of the sounds is peculiar. The interval between the

first and second sound is such as one would expect in a pulse of normal rate, while the interval between the second and first is several times the normal. The veins in the neck pulsate and at a much higher rate than the arterial pulse.

The lungs were quite normal.

The liver could be felt a short distance below the costal margin and was distinctly tender. The edge of the liver seemed quite smooth and there were no indications of any ascites.

All normal reflexes are present.



A polygraph tracing of the carotid and jugular pulse was taken. This showed most distinctly that there was a condition of heart block. The waves corresponding to the auricular systole (marked A) have no relation to the carotid and ventricular waves (C and D), each preserving their own rhythm. The rate of the pulse in this tracing was found to be 30, while the auricles had a rate of 75. A diagnosis of complete heart block was accordingly made. This case is interesting in that it illustrates the fact that in *complete* heart block the Stokes Adams syndrome of convulsions or syncope is very often absent.

The pathology of this disease is some lesion of the bundle of His, generally syphilitic. Usually a gumma or some scarring which interrupts the continuity of the bundle being found post-mortem.

I am indebted to Dr. French for permission to publish this case and to Dr. Hunt for the polygraph tracing and its interpretation.

ALAN McKENZIE.

Clubs' Union Year Book.

The new Clubs' Union Year Book for 1920 is shortly to be published. This year it will be issued in two parts, of which the first will be devoted to the affairs of the Constituent Institutions and the second to the names and addresses of life members. In order to make the first part more interesting than the past year books have been, it is necessary to secure the co-operation of the secretaries of the constituent and affiliated clubs and societies. The following details are required:—

Names of executive officers and committees.

Any alterations to rules.

Resumé of past season's activities with results of matches, etc., and names of teams.

Names of representatives on the Blues Committee.

Other details that may be of interest.

Mr. Winston will be obliged if secretaries will forward the above details to him at the Medical School office as soon as possible.

Presentation to Mr. Bromley.

On Thursday, July 22nd, in the Physiological Theatre, a presentation was made to Mr. Bromley to mark the close of his tenure of the positions of Dean of the Medical and Dental Schools and Warden of the College.

The President of the Residents (Mr. Kidman) spoke shortly of our appreciation of Mr. Bromley's services, and then, on behalf of the students and residents, presented Mr. Bromley with a clock, inscribed: "Presented to L. Bromley, Esq., M.C., F.R.C.S., by the Residents and Students, as a token of esteem and regard on his retirement from the posts of Dean and Warden at Guy's Hospital."

Mr. Bromley thanked the students for the clock and also for the consulting-room chair, which he had already chosen and received. As he still remained on the Staff of the Hospital (as Assistant Surgeon) and was not, in consequence, severing his ties with us, he had anticipated no such gifts. His term of office as Dean and Warden had made him more and more proud of sharing with us the privilege and honour of being a Guy's man. It was the same Guy's spirit which had made his position as Dean of the two schools almost a sinecure. He had found that every man was always only too willing to act in the way which he saw was the best for the Hospital, so that everything went on rapidly and smoothly with only the slightest guidance from him. Mr. Bromley next went on to speak of the Students' Club. He said that he had heard lately that the residents in the College were beginning to ask for better clubrooms and better catering. He could fully sympathise with their complaints. The College was designed many years ago; now (especially when one considered the numbers of students in the Hospital) it could well be much improved. With regard to the catering, he had lived as Warden in the College during three regimes, that of a private caterer, that of a manageress paid by the Club, and that of the A.B.C. Looking back, he said, it would be hard to say which had given least satisfaction. As for the residents of the College, it was a pleasure for him to live among a number of men who were so considerate, so quiet (except after Residents' dinners), and, in view of their many discomforts, so long-suffering. It was a sad day for him when he left the Warden's house.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of Guy's Hospital Gazette.

Practical Examinations in Midwifery and Gynæcology.

Dear Mr. Editor,—I understand that it is beginning to be recognised that the clinical examination in midwifery and gynæcology leaves much to be desired as a practical test of efficiency in these important departments of medical education. The establishment of such practical examinations as are successfully instituted in diagnosis for medicine and surgery and even in treatment for dentistry are really unthinkable in these two branches of professional work. Must we therefore give up all hope of establishing the fact that a student has practical knowledge of these subjects before he can obtain his qualification? I think not. The Reconstruction Committee at Guy's to which I had the honour of acting as first chairman expressed a strong hope that it would be found possible to include as part of medical examinations the school records of the candidates. Herein seems to be the possibility of an examiner in midwifery and gynæcology satisfying himself that a candidate is possessed of experience in diagnosis which from the nature of the case it is impossible for him to test experimentally at the moment of the examination. A candidate should be required not only to present certificates that he had held appointments in these subjects, but should be required to submit evidence that he has industriously taken advantage of the opportunities he has had of gaining practical experience while holding them.

In many universities it is customary in the Faculty of Science, especially the subjects of Biology, Chemistry and Engineering, for the college authorities to submit on behalf of each candidate his notebooks and other papers verified as being his own work and containing records of actual work undertaken by the candidate during his course of practical instruction. A similar procedure could surely be adopted in the case of out-patient clerks, obstetric dressers and externs. An official of the Medical School, Subdean or Registrar, might be required to present these records to the examiners and explain any points that needed clearing up. An occasional inspection of the department by or on behalf of the examiners should ensure that the methods there adopted for enabling the clerks and dressers to compile their records were satisfactory. If the marks obtained by each candidate for his records were added, in such proportions as may be agreed upon, to those he received for his written and oral examination the amount of attention given to their compilation would be much greater than that now commonly given to clinical reporting.

It appears to me that if the special necessities of these branches of clinical study compelled the adoption of some such system as this it would have a valuable influence on medical education generally. It might confidently be expected that a similar system would before long be adopted in many other, if not all, departments in the medical schools.—I am, yours very sincerely,

LAURISTON E. SHAW.

12, Park Square, N.W.1.

Dear Sir,—In "Notes on Small Pox" which you were good enough to publish in the last Gazette I see you have put down the mortality of "Alastrim" as 5 per cent. It should have been ·5 per cent. A few further notes on this disease may be of interest. Dr. Aragoa, writing in 1911, says 250,000 cases of Alastrim occurred in five or six of the States of Brazil in a few years. At the same time Dr. Armstrong, Senior Medical Officer of Health for New South Wales, described an outbreak of over 1,000 cases of smallpox in Sydney with only one death. He concluded that the outbreak "was identical with the epidemic infectious disease known as Alastrim, Spanish Measles, and Milk Pox, although in the severer cases he noticed the typical variolous odour."—Yours sincerely,

S. G. FLOYD.

Milton House,
Orsett Road, Grays.
August 1st, 1920.

Dear Sir,—The installation of an air-tight chamber at the Hospital recalls the suggestion made by M. Paul Bert, the French scientist and minister.

He found that under the pressure of 1 to 1½ atmospheres a mixture of nitrous oxide gas and oxygen produces a continuous insensibility which was to be highly commended for its safety. A permanent theatre and two, if not more, ambulance chambers were established. I have not the necessary references by me, so cannot give the exact particulars.

As I had, prior to M. Paul Bert, given gas and oxygen in a case of ovariotomy, his suggestion had a great charm for me. He made known his results the year that the initial address at the commencement of the October Session was generally given at Guy's, and in mentioning these to Dr. Steele (our then Superintendent) he was very desirous of having one for the conversazione that was to be substituted for the address. Time and expense, however, prevented this.

I am not in favour of nitrous oxide gas and oxygen for ordinary dental work, but prefer gas-air and a small percentage of chloroform. The blood contains a definite amount of oxygen, and it is certainly pernicious to breathe beyond a certain percentage; these being granted, I should prefer (with-

out presumption on my part) to breathe a small percentage of oxygen under pressure *à la* Paul Bert than a large percentage under ordinary pressure.—Yours sincerely,

TOM BIRD.

65, Conduit Street, W.1.
July 22nd, 1920.

P.S.—There is a direct local action of oxygen not here considered.

DEAR MR. EDITOR,—As one of the few survivors of the old Guy's Boat Club I send you a few notes. I was a member in the years 1863 and 1864 as far as I can remember. Cooper Foster was the President, and took a very deep interest in the Club, as I believe did Mr. Cock. When I was a more or less active member, T. A. Buck, still living, a former Captain of the Boats at Eton, was captain; there was also Owen Coleman, also surviving, a junior to us but a member of the Kingston Rowing Club; there was a Barrett, and Davies-Colley, Fagge and Stevenson were members also. The boathouse was at Putney, and we had an outrigger sculling boat and a four oar, and, at all events, the use of an eight oar.

We had rather before 1862 entered at Henley, I believe, for four-oared boats. Cooper Foster used to cox an eight-oar up to Richmond, give them dinner, and make them row him back to Putney. In my time there were some so-called Diamond Sculls, and my impression is that they were won by Davies-Colley.

I trained and rowed in an eight, and I shall not forget the state of exhaustion I was in at the end of a very hot day. I recall an amusing incident. An eight was judging a four-oared race, and somehow the cox was too intent on the race and the bow of the eight passed partly under the sloping stern of a barge; two members of the eight were for escaping on to the barge, but the captain, regardless of the fact that the two were junior members of the Staff, made rude remarks about their eyes and told them to sit down and back water. They did this and so ended the trouble. At that time we had several Oxford men who were interested in rowing. One was A. B. Shephard, whose brother Bob was stroke of the Brazenose boat and rowed in the 'Varsity race. Shephard was a good coach, and, like many such, his language was often strong. I was told that I never pulled my weight—in fact, I was hardly worth the fraction of a Damn. And now I have had my say.—Yours truly,

G. H. SAVAGE.

26, Devonshire Place, W.1.
July 27th, 1920.

Herpes and Varicella.

DEAR SIR,—The interesting article by Dr. Barber on Herpes in to-day's GAZETTE prompts me to put on record another case of associated Herpes and Varicella.

Mrs. H. developed Herpes Ophthalmicus on June 28th. On July 17th both her sons—aged 8 and 11 years—developed Varicella. A point to be noticed is that these boys differ by three years in age and are therefore not likely to have been simultaneously infected at school; moreover, their headmaster states that there has been no case of Varicella in the school, and I know of no case in their own neighbourhood.

In the various discussions and communications on the subject it is remarkable that little attention has been paid to the question of mutual protection. This would be valuable evidence since Herpes and Varicella themselves give almost complete protection against a second attack.

Dr. Barber says that many of his adult patients give a history of chicken-pox. This is a strong point against any etiological connection between the two diseases, but it would be of interest to know whether any of his patients had suffered from chicken-pox *shortly* before they developed Herpes. Chicken-pox is decidedly rare in adult life, while Herpes—at any rate in general practice—is not uncommon in elderly people, and it is possible that the immunity acquired from an attack of Varicella in childhood has become "worn out" by the time the Herpes has developed.

It would be a help to have answers to two questions:—

1. Is there a case recorded of both Herpes and Varicella occurring—not simultaneously—in the same patient during childhood?

2. Is there a case recorded of Varicella in an adult who had previously suffered from Herpes?

I regret that I have not paid attention to these points in my own cases, but my patient, who is now recovering from Herpes, assures me that she has never had chicken-pox. Sufficient time has not yet elapsed to show whether she has escaped infection from her children.—I am, yours etc.,

H. M. STEWART.

Dulwich.
July 24th, 1920.

P.S.—Since writing the above I hear from a medical neighbour that three weeks ago he attended a case of Herpes in a girl aged 14, and that a fortnight later a younger sister developed chicken-pox. But does Herpes ever give rise to a second case within the vaccination period of Varicella?—H.M.S.

DEAR SIR,—I am much interested to see in the GAZETTE an account of the re-formation of Guy's Hospital Boating Club. The Club was re-founded after a lapse of some years in 1887. Mr. J. N. C. Davies-Colley was President, Mr. E. J. D. Mitchell Captain, Mr. A. G. Bowen Secretary, and Mr. Walter C. Swayne Treasurer. A four was entered for the Inter-Hospital Cup as follows:—

	Bow
H. W. Whyte	2
A. Allport	3
E. J. D. Mitchell	Str.
R. J. Roberts	Cox

In 1888 the Cup four was:—

Walter C. Swayne	Bow
A. Allport	2
F. G. Swayne	3
A. E. Durham	Str.
G. Worts	Cox

A four also competed for the Molesey regatta:—

H. E. Durham	Bow
A. Allport	2
F. G. Swayne	3
E. M. Pilcher	Str.
S. Worts	Cox

E. M. Pilcher was Captain in 1888 and W. C. Swayne Secretary. Pilcher was prevented from rowing in the Cup four by an examination.

In 1889 the Secretary was H. E. Durham, now at Hereford. My memory will not carry me further than this, and some of the details I have given may be inaccurate.

In 1888 the Cup four was beaten by St. George's by a quarter of a length after leading over the Putney-Hammersmith course as far as the soap works.

I hope that the Club will be successful.—Yours faithfully,

WALTER C. SWAYNE.

2, Clifton Park,
Clifton, Bristol.
July 27th, 1920.

MOST SAGACIOUS SIR,—It is well known to us in China that the brain of your European women reproduces many features of that of man, and that although indeed many areas such as those of Broca and the region of the hypoglossal nucleus is regrettably hypertrophied in ninety-nine per cent. of cases, yet there is on the whole much that recalls the species "Homo Sapiens."

Yet, in our country, if we have neglected development in this direction we have gained more perhaps in the development of the dumb animal. In this direction much has been done, and the revised regulations of the University of Pekin admit, without distinction of sex or species, all students whether dumb or eloquent, with the sole exception of such creatures as inhabit the menageries, for which the authorities of the colleges have not yet provided suitable accommodation; for these, however, arrangement are being made so that educational opportunities shall not be completely denied them, and we confidently anticipate in China a very rapid intellectual development of all. For you must understand that it is no argument to say that the dumb animal is biologically weaker and destined to be subservient to man; it is all a matter of training. For thousands of generations men have kept these animals as their servants simply because the latter were too poor or too proud to argue, and this state of affairs cannot last. Nothing can oppose the onward march of pure reason!

Let us open then our Universities to all races and species of creation as Noah did. Let the sagacity of the dog and the artistic temperament of the cat not less than the ingenuity of the boa constrictor be cultivated in the best interests of the State. And I would favour a free intermingling in the colleges. Why should man be allowed to escape from the company of cat and dog. By what right does he arrogate to himself the prerogative of seclusion and selfishly shut himself in monastic separation. Give the horse a chance; let every dog have his day; let the cat spend at least one of her lives in educational pursuit. We have need of the co-operation of all.

You must admit the magnanimity of the proposal!

Much has been done in Pekin already. The names of the streets have been written lower so that the bus horses and others may read them as easily as their masters, and this has practically enabled the companies to dispense with conductors, the horse simply neighing the name of the neighbourhood. The movement has been largely helped by the Anti-vivisectionists. It has been pointed out that it is not fair that doctors should practice on dogs before they practice on men, but rather that it should be the other way round, and those who aspire to veterinary science should take out their diploma first in medicine.

One of our leading ophthalmologists has set a good example here, and his work in combating astigmatism in rats and mice and presbyopia in owls, has been revolutionary. The ignorant little realise what untold suffering has come of deficient vision among quadrupeds and the work of Pooh Pooh as honorary ophthalmologist to the Pekin Dog Home in providing so many poor pups with Crooks' tinted spectacles is quite beyond praise.

I hope in Europe you will not withhold from the movement, nor foster any longer your prejudices but rather that you will admit, as we do, the right of development to all, and open the doors and windows of your Universities and Colleges, aye, of Medical Schools, to all forms of microscopic and macroscopic life.—Your humble servant,

HO. HO.

The Prize Giving.

The annual prize giving was quietly held on Thursday, July 8th, at 3.30 p.m. Before the war this function was combined with the Garden Party. The Staff appeared resplendent in their academic robes. A large gathering of ladies was there, and filled the Physiological Theatre. The speeches were dull—how could they be otherwise when the audience was so out of sympathy with the speakers? For most of the students, availing themselves of the opportunity offered by a compulsory half-holiday, and knowing that the Theatre would be filled with other people's lady friends, had gone joyously off to play cricket or tennis.

This year the whole atmosphere was different, and there was no one who did not welcome the change. The audience was exclusively composed of Guy's men—staff and students. Lord Goschen himself found time to come and take the chair and distribute the prizes. His presence was exceedingly welcome. His work for the Hospital is too little known to the majority of the students—indeed, many of them do not even know him by sight, a fact attested to by the remark of a very young student, who, half

way through the proceedings, said "Who is that man in the chair?" We are glad to think that the prize-giving gave a large number of students the chance of seeing our Treasurer, and, from the lips of Dr. Fawcett and Sir Alfred Fripp, of learning something of the benefits that accrue to the Hospital from his tenure of an office which is no sinecure.

Any anxiety which anyone may have had as to there being a good attendance was speedily put at rest. The Physiological Theatre was comparatively full, but men would insist on crowding round the steps near the doors instead of taking the numerous empty seats nearer the front—another example, we suppose, of a national characteristic which is daily demonstrated on the tube railways.

The proceedings ended with three cheers for Lord Goschen and an enthusiastic rendering of "For he's a jolly good fellow." Altogether it was a great improvement on the old prize-givings, and we hope that the innovation will become a custom. Although the attendance was good the Theatre will hold a very large number, and we hope to see even more men in coming years; and if the procedure is as simple and homely as it was on this occasion we can be confident of crowded houses in the future.

Inter-Hospital Boat Race.

This event was rowed over the Putney-Hammersmith course on Saturday, July 31st. The last race was in 1913, when St. Bartholomew's won with a good four which included C. E. Kindersley at stroke and C. W. B. Littlejohn, the old Oxford Blue, who rowed "7" behind R. C. Bourne in several successful Oxford crews, and who was "3" in the four who won the Stewards' Challenge Cup at Henley for New College in 1912 and 1913, at "3." The 1913 race was the first in which coxswainless boats were used. The previous races until 1910 had been rowed in light coxed fours, but there was no race in the years 1909, 1911 and 1912.

This year the precedent set in 1913 was followed, and light coxswainless boats were used, Guy's and St. Bartholomew's, the holders, being the only two crews competing. The latter have been successful in this event on many occasions, and the names of St. George's and London also are conspicuous on the handsome challenge trophy, which was first competed for as long ago as 1885. But although this date represents the establishment of the existing Challenge Cup, there were many inter-hospital races in earlier years, but I cannot say whether there was an older challenge cup or not, or, if there was, what has become of it. The name of Guy's on the cup is conspicuous only by its absence, and I can only express the hope that now the ice is broken future crews will remedy this lamentable deficiency.

The fast motor launch "Thelma" followed the race with the umpire, Mr. H. S. Souttar, of the London Hospital, on board, as well as Sir Alfred and Lady Fripp, representing the Staff of Guy's. The conditions were as near perfect as possible. It was a warm and sunny afternoon, with a light easterly breeze blowing up the course. A moderate tide was running up, and the water would have done credit to an up-river course. St. Bartholomew's, winning the toss, selected the Surrey station. The crews got away from their stake boats at a few minutes after two o'clock, and St. Bartholomew's, rowing the faster stroke, lead by a canvas at Putney Dummy. From this point Guy's gradually drew level, and had about half a length at the London Rowing Club. Faulty steering on the part of St. Bartholomew's brought the crews dangerously close together, and about opposite the Thames Rowing Club they got entangled and had to stop rowing. After a few mutual recriminations they both got going again, but, after passing Beverley Brook, St. Bartholomew's got out of their course and pressed Guy's into the Middlesex shore. It looked as if a crash was inevitable, but the umpire stopped the race and asked Guy's if they would claim the race on a foul. This they refused to do, and asked to be started again from where they were. The umpire agreed, and a fresh start was made. St. Bartholomew's steered too far into the bay, and by Harrods Guy's had a length's lead. After this St. Bartholomew's came up fast, and Guy's were unable to respond. It looked for a time almost as if Guy's would be defeated, but they pulled themselves together and just managed to secure the verdict by a quarter of a length.

It was unfortunate that the foul occurred. Still more unfortunate, perhaps, that the word foul, with all its unpleasant associations, should be used in rowing when one boat, especially one without a cox, runs into another. In some branches of sport fouls are things which may be done deliberately in the hope that the umpire or referee may not see and that unfair advantage may be taken of the other side. In rowing no possible advantage can accrue to a boat that fouls another, and I hope that every one will realise this important fact. Admittedly St. Bartholomew's steered badly, but let no one criticise them too severely who has not himself attempted to steer a coxswainless four. But for this it was a splendid race, worthy of the traditions of inter-hospital rowing, traditions which I can only hope will be as worthily upheld in future years.

Officials.—Umpire, Mr. H. S. Souttar (President U.H.R.C.); judge, Mr. R. MacLaren (L.R.C.).

Crews:—

Guy's Hospital.
Bow, R. S. Chambers.
2 (steers), M. E. Shaw.
3, F. C. Miller.
Str., A. T. Fripp.

St. Bartholomew's.
Bow, H. K. Denham.
2, B. M. Tracey.
3, R.Claber.
Str. (steers), D. C. Fairbairn.

Marriage.

ATTWATER-JONES.—On the 14th of July, 1920, at Holy Trinity Church, Rathmines, Dublin, by the Ven. J. K. Latham, D.D., Wilfrid F. Attwater to Marion, younger daughter of J. Jones, Esq., of Park, Wexford, Ireland.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Front Surgery, as we mentioned in our last issue, has for a long time been a source of contention and dissatisfaction to those students to whose lot it falls to work there. Much, if not all, of this will be removed by the new system of administration which was introduced a fortnight ago. The new scheme is much the same as the one obtaining last year with a few important alterations which are decided improvements. In the first place, the list of dressers is posted for a month in advance; in the second place, an elaborate system of substitutes is provided in case a dresser should fail to fulfil his appointment. While we should like to congratulate the authors of this new arrangement on producing a carefully thought out scheme which will do much to meet the perpetual grumblings which have recently been so common, we would also add a word of warning to those students who are involved in Front Surgery work. No scheme for running any Department of the Hospital with student assistants can possibly work smoothly without the full co-operation of the students concerned. This is, perhaps, more true of the Front Surgery than of any other Department of the Hospital, and we doubt if the fact is fully realised. Much of the confusion which has arisen in the past six months from the not infrequent eleventh hour changes in the dressers' list has been brought about by the dressers themselves defaulting without giving adequate notice. There are certain emergencies which justify a dresser in not giving notice of his inability to do his work. Such emergencies are rare, and personal experience compels us to admit that the absence of a dresser from the Surgery is an occurrence too frequent to be accounted for by such mishaps. If only dressers would realise the damage caused to the tempers of their colleagues and of the O.P.O.'s—and incidentally to their own reputations—by failure to fulfil their obligations, the present scheme should prove a great success.

JUST at the moment all organisation is hampered by shortage of senior men in the wards—the inevitable result of the war. It was hoped that by this time the "Unit System," which was introduced last year, would be in full swing and that each unit, *i.e.*, the united forces of a medical with its corresponding surgical firm, would be able to undertake the res-

ponsibility of "running the Hospital" for a week at a time. This is at present impossible for two reasons. In the first place there are not enough men to make it feasible. This deficiency, however, ought to be remedied by next October. The second difficulty is the more real and, unless steps are taken to circumvent it the unit system will be nothing more than a name for many years to come. When the old Clinical ward was demolished it was decided that each physician should do "Clinical" in his own wards for three months at a time. This means that, as far as "running the Hospital" is concerned, there are now only three medical firms to correspond to the four surgical. Each three months one surgical firm must be without its medical colleagues. Under such conditions any attempt to work a unit system becomes impossible and the impossibility will remain until the old system of Clinical is reverted to. But this requires a separate Clinical ward, and, though it is proposed to build a new Clinical on the top of Hunt's House, it must be many years before the work is completed. Being firm believers in the unit system, we are glad to hear that an attempt is being made to solve the problem. It has been suggested that the nurses' dormitories included in the upper part of the building now being erected on the old site of Clinical should, when complete, be temporarily used as a Clinical ward until the new one is built. The increased number of nurses needed now that the hours of the working week are being diminished—a much-needed reform—will throw an additional burden on the nurses' accommodation, and very probably the Matron's department will look with disfavour on a proposal which tends to add to the difficulties of administration. But we are sure that ultimately it will be to the good of all concerned with the Hospital, patients included, to get the unit system into proper working order, and we hope that every effort will be made to find an alternative method which will both preserve the appointment of Clinical intact and at the same time obviate the necessity of obliterating a medical firm every three months.

Now that In-Patients at the London Hospital are being charged a small weekly sum towards their maintenance there is an increasing number of patients from the east end who seek admission into the wards of Guy's and also, we imagine, of the other hospitals who have not followed the lead of the London. In normal times the competition for beds in Guy's is very considerable, as a glance at the R.S.O.'s list will testify, and the situation will not be relieved if we have to cater for an area which has hitherto been dealt with by another large general hospital. We do not know how the new system at the London is working—except for the above observations—but we do know that the financial crisis which precipitated their action is present with all hospitals at the present time and is causing grave concern to those responsible for their management. In the Annual Report of Guy's Hospital for 1919 the Governors make an urgent appeal, especially to commercial firms in Bermondsey, Southwark, and Rotherhithe to swell an annual subscription list which has always been absurdly small considering the enormous expenditure involved in the adequate administration of an up-to-date modern hospital. It is pointed out that the total net income from all sources is only £80,000. This sum, unlike miners' incomes, is not indefinitely expansible. Indeed, it is not expansible at all in spite of the fact that an annual expenditure which, in 1914, stood at £76,000 has now risen to £130,000. To meet this deficit of £50,000 the Hospital boasts a yearly subscription list of under £3,500! During the

past year rather more than 8,000 In-Patients have been treated at the Hospital, so that, if the deficit were to be met by charging patients, a levy of £6 per head would have to be made. The average length of time that each patient remained in hospital was 24 days, so that the £6 would represent a charge of about £2 a week. It is clear, therefore, that even if a small charge to patients were contemplated, which is not the case, it would be quite impossible to meet the annual deficit from this source alone. Under these circumstances we wish every success to the appeal, but we cannot honestly say that we are confident that it will raise the required sum when we consider the numerous other appeals of a similar and equally urgent nature which are at present in circulation. To make a definite charge to patients is not considered to be in accordance with the Will of the Founder, but we hope that more will be done to secure donations from patients and their friends. There appear to be quite a number of in-patients, and even out-patients, who could well afford some contribution to the Hospital funds, and, while we recognise that many of them realise and fulfil their obligations in this respect, we feel that there must be many who do not simply because the facts of the case have not been adequately brought to their notice. But when all sources of revenue from voluntary subscriptions and donations have been tapped there will almost certainly still be a deficit which can and must be met in only one way—by State aid. There are few, if any, who wish to see our great voluntary hospitals become mere Government Departments. State aid to institutions and universities has been a perpetual bogey in the past, and we hope that in the future it will be shorn of many of its terrors, for it appears to be as inevitable as an eclipse of the sun. There is no reason why contributions from State funds should be accompanied by any intolerable degree of State control. If the State are prepared to treat the matter in a generous spirit and to realise the great claim of the voluntary hospitals, and all that they stand for, there is no reason why any hosptial should, in the future, be hampered by lack of resources from carrying on and extending that great work for the Country which, in the past, has been their conspicuous and self-sacrificing contribution to the cause of suffering humanity.

The Clubs' Union Council recently considered the question of the proposed enlargement of the Students' Club. Our readers may remember that this proposal, which was mentioned in the Gazette some months ago, involves the acquisition and alteration of the warehouse immediately adjacent to the College. Extension of the Students' Club is urgently needed, not only because the present Club accommodation is inadequate, but also because there is a large waiting list of men requiring rooms in the College, and, by getting rid of the Club rooms at present occupying space in the College, more residential rooms could be provided. We understand that the cost of converting and running the warehouse as a Club is too heavy to be contemplated by the Clubs' Union, sympathetic as they are with the idea. If it is impossible for them to carry it out, we hope that the proposal will not be allowed to drop. It is in the interests of the Hospital, by providing better accommodation for their Resident Staff, of the College, by securing more and better rooms for resident students, and of the Medical School, by being able to offer greater attractions to the prospective student (and his parents) that the suggested enlargement should be carried out, and we hope that, by conjoint action, something may yet be done where individual enterprise is impotent.

An American's Impression of Guy's Hospital.

By EDWARD J. WOOD, B.Sc., M.D., D.T.M. Eng.

Member of the Association of American Physicians.

A stranger is able to throw off the strange feeling quicker at Guy's than in any other clinic in the world with which I am familiar. On every hand he is cordially received and made to feel welcome. During the better part of a year it was never my lot to receive a rebuff though I was conscious of the probability of many violations of established custom on my own part.

If I were asked to tell why to the very ends of the earth Guy's is so highly rated, my reply would be, first, its splendid traditions, second, the spirit of the whole institution, third, the general plan of work.

No American, especially of the period influenced by the great spirit of Sir William Osler during his sojourn with us, could fail to appreciate the importance of the remarkable splendour of the traditions of Guy's founded not on fancy or a fleeting popular note, but on that stability which characterised the work of Addison, Bright, Hodgkin, Sir Astley Cooper, Gull, Wilks, and many more whose names should be included, especially on the surgical side. In America we are "brought up" on the names of these men, not as men, but as great morbid anatomists first and as great clinicians as a natural consequence. No greater inspiration in medical Europe is to be found than that of quietly and without haste going carefully through the matchless Museum and *actually handling* the pathological specimens placed there a century ago by this great group of teachers. The kidneys of Bright, the adrenals of Addison, the lymph glands of Hodgkin, may well be the start of such an excursion, but there is little chance that one will stop there. I was particularly interested in the twenty-two cæcal appendices dating back as far as 1802. To go through the records, so easy of access, and see just how carefully the findings were recorded and how nearly correct they are according to our present light, will prove a stimulus and an inspiration for a further study of old museum morbid anatomy. Sir William Osler taught that the old men should read the journals and new books while the young men should read the old books. May I add that the young men should also study and handle the old museum specimens?

Anyone who feels that Guy's is living on the glory of the past is simply ignorant of the real facts. My own feeling is that there are as many Addisons, Brights, Coopers, and Hodgkins at work there to-day as there ever were. And in place of its being a mausoleum of ancient achievement it can be safely prophesied that in addition to the brilliant work of to-day there will soon appear another great burst of medical glory, for I found young plants nearing the fruit of an extraordinarily superior quality. It is the spirit of Guy's that young men should have their fair show and should begin to create so early in their careers that they will not be timid or over-awed by the incorrect opinions of more seasoned men.

Much medical error is passed on in medical text-books from one generation to another, because the average man has too much of this sort of traditional timidity. I know this because in the past I have been among the guilty, but my contact with the present day spirit of Guy's has entirely unshackled me, and I will in future be found doing as they are to-day doing: accepting nothing without convincing proof. Another feature of Guy's, as I saw it, was what we call in America "team work." There may be bickerings among the staff, but I never knew it nor suspected it. All I saw was one department supporting another; no unit in the great machinery working alone, but all so perfectly co-ordinated that it was difficult to tell where the work of one ended and the next began.

In the general plan of work nothing impressed me more than the close relationship of the wards to the post-mortem room and the general practice of doing post-mortems. Few deaths occurred during my stay without a post-mortem being done. Indeed the success in this respect was almost as complete as what I saw in Fr. Müller's clinique in Munich in the old days. The practice of the assistant physicians doing a portion of the post-mortems is one of the most admirable to be found in any institution, and it is to be hoped that in America we may some day institute such a plan. No man, however learned in medicine, will ever do or see

done a post-mortem without learning at least one new thing, and oftentimes he learns many new things, some of which may startle him. Certainly the continual attendance on post-mortems will keep any clinician humble and free from all vaingloriousness. One day at 2 o'clock, while hurrying to the daily post-mortem, one of the clerks, who should also have been on the way, declined to join me because the case was one of lethargic encephalitis, and having seen one such, he thought there was nothing more to learn on the subject. However, following my more mature lead he did join me, and we saw Dr. Ryle remove a remarkable cerebral tumour which, strange to relate, proved to be bilateral!

The clerking privileges and opportunities cannot be excelled in any hospital with which I am familiar, and it is to be questioned if the clerks quite appreciate it. Nowhere else will they have such a chance to learn the value of routine physical examination. No partial examination ever leads to any goal but that of distressing oversight of some elementary fact. If the throat is left out somehow or other the case usually manages to be diphtheria, and when the urine is not examined the diagnosis of diabetes may be suspected. It is in the wards that the student begins to acquire the habit of reviewing his case almost unconsciously system by system, passing from the circulatory to the respiratory, the renal, the nervous, the blood, and so on. Our saddest mistakes are oversights and there is no better training to prevent them than that of Guy's to-day.

Such a communication would be sadly inadequate without a further reference to the Museum. I was unable to determine if it was appreciated. It certainly is a "pearl without price," not to be equalled in any other institution to my knowledge. The wax models of the anatomical preparations will always be a source of wonder and amazement to me. Surely they must serve to rid anatomy of much of its horror. This alone would attract me to Guy's were I seeking a Medical School. The wax models of the skin lesions are equally remarkable. It gives one the impression that the work was done not only by a great artist, but also by a wonderfully acute medical observer. The bone preparations were of peculiar interest to me and deserve careful study for days before being discussed. It is hard to conceive of any pathological process which is not well represented. What a task it must be to keep up this work, especially, as I know from experience, in the light of greatly increased costliness of preserving glass-ware and chemicals. But it must go on, and it surely will!

I have said no word of criticism, and, indeed, I have none, for my whole time was occupied with the great array of matchless advantages, and I felt troubled continually because of my inability to grasp it all. If I were to be an undergraduate student again I would like to have more actual blood counting to do in the wards. Without a blood counter always at work an American feels lost. It is remarkable how it has a way of throwing light on obscure places. The differential count is no less valuable. The routine taking of blood pressures would be a great help in the wards from my own point of view, though I am well aware of the great objection to it in the high places of British medicine. Few there are who can form an opinion of degree of tension by palpating the radial artery. If blood pressure observations are to be relied on, the observer should be familiar with the technique acquired by continual repetition. In spite of the teachings of Dr. Thomas Lewis and Sir James Mackenzie I shall continue to do auscultatory estimations of both systolic and diastolic pressures in every case coming under my observation. Many elevations of temperature are never suspected until a routine use of the clinical thermometer reveals them; so too many high and low blood pressures go by us unsuspected unless instrumentally studied. It is to be hoped that some skilful juggler of the medical curriculum will some day find a place for the time necessary for the clerks to make routine blood sugar and blood urea estimations as well as other blood and urine procedures of practical value at the bedside. But all these asides are not criticisms, for it is obvious that in the medical course only a start in medical knowledge can be made. The time element is the difficult thing at Guy's, as at all schools, and as something must be omitted, I believe Guy's has chosen the better part.

It is rather remarkable that while Guy's must be regarded as a training place for the undergraduate essentially, the fact remains that I, personally, found it admirable for postgraduate work. The material in the words as well as the Out-Patients was seemingly limitless and

one could follow out any particular line of clinical research desired. The plan of naming postgraduate students assistants in the various services is an excellent one, serving the purpose of giving the worker a status which is absolutely essential for satisfactory work. The wards were open to me and through the courtesy of the house physicians and with the sanction of the physicians I was able to see those neurological cases in which I was interested in the four medical wards. Few places anywhere can boast such a variety of neurological cases, and the same holds for almost all branches of clinical medicine. The postgraduate is given every facility for individual work, and the direction of his efforts can be shaped by the ablest supervisors—the physicians—who from time to time will go over his work with him and help him in his difficulties.

I found the ward rounds of the greatest value and to me the instruction seemed to be particularly adapted to my special needs. The postgraduate must have been more helped than the undergraduate, though I have not familiarised myself with the latter's views. Certainly the latest work in the subjects under discussion was fully discussed, and while the facts were made quite plain, even to the undergraduate, there was nothing omitted which the postgraduate might wish.

One of the most fertile sources of help to the postgraduate, though planned for the undergraduate, are the conferences in which the various divisions are represented in the form of a consultation. That is, for example, a conference over a gastric case in which the physician, the surgeon, and the radiologist take part, setting forth their views from their respective angles. One of the most helpful that I was fortunate enough to hear was taken part in by the physician and the dental surgeon.

Let me say, in conclusion, that not the least treasured experience of my month at Guy's is the acquisition in a measure, at least, of the Guy's spirit which will influence all my future work. It will be with considerable pride that I shall claim Guy's Hospital as one of the sources of my medical training.

[NOTE.—The above remarks are based only on a physician's experience, hence the apparent neglect of the surgical aspects of the institution.]

Some Notes on a Case of Nerve Injury.

BY W. H. OGILVIE, F.R.C.S.

THERE is an ex-soldier at present in No. 28 bed, Astley Cooper ward, whose injury, while it is by no means unusual, presents several points of interest which are, perhaps, worth discussing, in view of the fact that he is still in the Hospital "to point the moral and adorn the tale." I venture, therefore, with Mr. E. C. Hughes' kind permission, to publish these notes.

History.—He received a through and through wound of the upper arm at Vimy Ridge on the 9th of April, 1917, followed by immediate paralysis of the median and ulnar nerves. The wound healed rapidly. After eighteen months in hospitals at home, his nerves were sutured by Mr. Steward at Guy's in November, 1918.

Condition on Admission.—Appearance.—The right forearm is well developed, though smaller than the left. The hand is a "flat" hand, the palm not showing the hollow of a normal palm. This is due to two factors: the extreme wasting of the thenar and hypothenar eminences, and the fact that the thumb is held back in the same plane as the fingers, giving the so-called "ape hand" deformity. There is wasting of all the interosseous spaces.

Sensation.—This was not tested in detail. He can feel the prick of a pin over the dorsum of the hand and fingers, and over the palm. On the flexor aspect of all the fingers he only occasionally feels the pin point, and this not as a painful sensation. Manipulation of the ulnar nerve at the elbow produces no pain and no tingling referred to the ulnar side of the hand.

Voluntary Movement.—Flexor carpi radialis, pronators, long flexors of fingers and thumbs, all act well. Lumbricals, interossei, median intrinsics, no voluntary power. The one doubtful muscle was the flexor carpi ulnaris. During wrist flexion its tendon feels quite slack to palpation.

Electrical Reactions.—Faradism: all muscles of forearm except flexor carpi ulnaris react to Faradism. No intrinsic muscles in hand react

to Faradism. Galvanism: Reaction is barely perceptible in intrinsics of hand, except in the case of the adductor pollicis.

Provisional Diagnosis.—The median has recovered as far as the long bellies in the forearm only. There is no recovery of the ulnar.

Operation.—A nine inch incision was made in the line of the ulnar nerve, reaching to the apex of the axilla and including the old scar. The internal intermuscular septum was found to be marked by a glistening tendon the size of that of the plantaris, and circular in section. The ulnar nerve was isolated below the old suture level, and also in the axilla, and traced up and down, till it was exposed in the whole length of the incision. The sutured portion showed a fusiform swelling 2 inches in length. The isolated nerve was then stimulated above and below the swelling with the Faradic current. On each occasion a contraction of the flexor carpi ulnaris was obtained, but of no other ulnar supplied muscle. Thus the diagnosis of a complete block to conduction at the old suture line was wrong, and the operation was concluded by closure of the incision.

Points of Interest.—(1) Difficulty in diagnosis.—It is often a very difficult matter to decide whether there is any recovery in a nerve when the case is first seen some time after division, or after an operation for suture.

Immediately after division of the ulnar nerve in the arm, the anæsthesia is usually complete over the whole area of anatomical supply of the nerve. A year after division, even where there is no recovery, there is complete anæsthesia only over the little finger, and merely hyp-æsthesia over the rest of the ulnar supplied area. Sensation to light touch and temperature sense are absent in the little finger, but these are often very imperfect for over two years even where recovery is actually taking place. A pin prick, though not giving a painful sensation, is very accurately localised by the sense of vibration given to the hand as a whole. With the hand laid on a table and the eyes blindfolded, a man can localise pin pricks on the table itself to some extent. Sensation then is not a great help in this case.

Muscular action is more reliable, but in this case it was fallacious. The wasting of the intrinsics tells at once of an ulnar lesion, but does not say whether it is complete or incomplete. All movements of the ulnar intrinsics, with the single exception of abduction of the little finger, can be mimicked to some extent by other muscles. This man shows these deceptive "trick movements" very well, and for this alone is worth examining.

He partly extends his two distal phalanges with the long extensors. He flexes his metacarpo-phalangeal joints with the long flexors. He abducts his fingers very passably with the long extensors, and adducts them by means of the long flexors. He adducts his thumb to the index by the combined action of the long extensor and long flexor of the thumb.

Coming to the long bellies, voluntary contraction of the ulnar half of the flexor profundus is always, of the flexor carpi ulnaris often, difficult to prove when feeble; while, as in this case where the nerve supply has actually returned, weak Faradic stimulation may fail to give a response while strong stimulation spreads to adjacent muscles. The only sure proof is direct Faradic stimulation of the nerve trunk.

In this instance what appeared to be decisive in favour of a complete block to conduction was the insensibility to pressure of the ulnar trunk. This nerve sensibility is usually increased in the case of a recovering nerve.

(2) Exposure of the Ulnar Nerve.—At the elbow this is easy. In the lower third of the arm the nerve often lies, as in this case, deeply in the substance of the inner head of the triceps, and not just under the deep fascia. Separation of the muscle fibres in the line of the nerve with a blunt dissector will expose the plexus of veins accompanying the inferior profunda artery, which are a sure guide to the nerve at this level. There is no danger of mistaking for the ulnar either the internal cutaneous, which is much smaller, or the median, which is closely applied to the brachial artery.

In the axilla the ulnar is readily found to the inner side of the artery. The only nerves of a similar size here are the musculo-cutaneous, musculo-spiral, and median. The former two are well out of the way, one externally the other behind. If there is a doubt whether the median has been exposed, this is settled by tracing the nerve upwards, when in the case of the median the two heads are brought to view. Faradic stimulation will settle any difficulty as to the identity of an exposed trunk, and such an apparatus is essential in any nerve operation.

(3) The tendon overlying the internal intermuscular septum.—This was probably that of an occasional insertion of some of the fibres of the coracobrachialis. In Bland Sutton's "Selected Lectures," chap. ii., page 11, he says, "The third piece (coracobrachialis longus) may exist as a muscular belly extending from the common tendon to the internal condyle. Its position is usually indicated by a thin tendon attached to the internal condyle. When a supracondyloid process is present, this portion of the muscle is inserted into it."

(4) The question of proceedure at the operation.—Since twenty months after suture only one ulnar supplied muscle showed any signs of recovery, would it not be wiser to resect the old suture line and make a new one? With nothing else to go upon it might have been the right course to do so. The median nerve, however, supplied the key to the probable pathology, that the new axis cylinders had grown down and were carrying effective impulses to the long bellies, but that there was too much atrophy of the intrinsic muscles of the hand to allow any recovery on their part. There was probably a similar reason for the non-recovery of the ulnar intrinsics, as these gave a barely appreciable response even to galvanism. Had these muscles been known to be healthy, and yet remained paralysed twenty months after suture, it would certainly have been right to do a fresh suture, for the lumbricals and interossei are of an importance compared with which loss of power in the flexor carpi ulnaris matters very little.

(5) Prognosis.—Following suture of the median or ulnar nerves in the upper arm, it is not at all uncommon to find the muscles in the forearm recover voluntary power rapidly and completely, while sensation in the hand returns much later, and power in the intrinsic muscles little or not at all.

There are several factors concerned in this. One is, of course, that any nerve trunk is a bundle of sensory, motor, or sympathetic branches contained in a common sheath, but otherwise running as isolated units each in its appointed distal termination in muscle, skin, joint, vessel wall, etc. After resection of a portion of a nerve and suture of the ends, however great the care that has been taken to prevent axial rotation, it is impossible that each bundle in the upper end should have been exactly approximated to its fellow in the distal end. Thus, some sensory fibres will grow into motor sheaths and vice versa, and will eventually arrive at an end organ to whose function they have not the key. Hence suture of the musculo-spiral, an almost purely motor nerve, is nearly always rapidly and completely successful, chiefly because motor fibres have so few chances of taking the wrong turning.

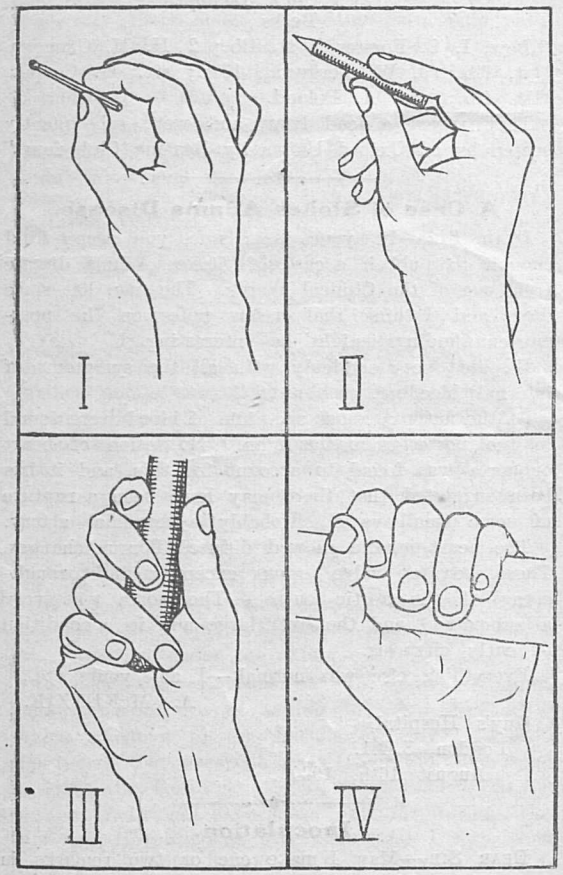
In the case of the intrinsics of the hand, a more important factor is circulation. A paralysed muscle tends to atrophy and become fibrous tissue, and it is only where treatment has prevented this atrophic process in the muscle that a nerve suture can be followed by recovery of voluntary movement. Warmth is one of the most important factors in hastening the recovery of paralysed muscle, a fact illustrated by the greater rapidity with which cases of anterior polyomyelitis recover in summer than in winter. The hand is much more exposed to changes of temperature than the rest of the arm, and in addition to this the arterioles in cases of nerve injury are known to be liable to an endarteritis which narrows their lumen. This man has had excellent treatment, as is shown by his freedom from contractures or stiffness of joints, but in spite of this and of Mr. Steward's successful suture twenty months ago, his intrinsics have not recovered and are unlikely to do so, because they are no longer muscular tissue. On the other hand further improvement in sensation is still likely.

(6) The future usefulness of his hand.—Here we have loss of all the intrinsic muscles in the right hand. Of these the median intrinsics bring the thumb into apposition with the remaining fingers in the finer movements of grasping objects with the pulp of the fingers. The interossei abduct and adduct the fingers; they also perform the movements of extension of the last two phalanges. The lumbricals flex the metacarpo-phalangeal joints.*

One has, however, to consider the hand as a whole, a point of view very ably discussed by V. Putti in his papers on the utilisation of the muscles in amputation stumps. The hand is a mechanism for grasping. Extension of the fingers is a weak movement, and one that cannot be sustained. It is never used actively, but is merely an opening of the grasping mechanism to the required extent.

*Colin Mackenzie. "The Action of Muscles." 1918.

In performing its functions as a grasping machine, the hand employs two kinds of muscular action—power and accuracy or steadiness. Power is supplied by the long flexors, steadiness and accuracy of direction by the intrinsics, and the part played by each factor varies according to the use to which the hand is put. In all the finer movements, the power supplied by the muscular bellies in the forearm through their long tendons can only be effective when the points of application of this power, the finger tips, are directed and held steady by the interossei, which brace the metacarpo-phalangeal joints on each side like shrouds along a mast. Pick up a pin between the thumb and index; the first dorsal interosseous will immediately be felt to contract on the radial side of the index metacarpal.



Then, again, the action of the hand may be looked upon as divided into four different grips (see figures). There are :—

1. The two-finger grip, used in the handling of fine objects such as a pin or a match, or in the fine work of a watchmaker. It depends more on steadiness than power.

2. The three-finger grip or "triangular grip" of Vanghetti, used in holding a brush or pen.

3. The four-finger grip, used, for instance, by a wood carver in guiding his tool on the wood. Here the ring finger supplies the powerful grip, while the thumb, index and medius direct the tool. To a worker who uses his hand as a "four-finger grip machine," the loss of the ring finger is a serious disability.

4. The whole-hand grip of the heavy worker, used in handling a pick or hammer, or in carrying a bucket. Here power is everything and accuracy very little. The thumb is only important when the object grasped is a large one.

An artificial hand can only imitate one of these grips, and in choosing its type the work of the patient and the grip appropriate to that work must be considered.

A practical experiment illustrating the effect of cold on the circulation to the intrinsics of the hand, and demonstrating the part these muscles play, is easily carried out by a 50-mile motor cycle ride on a frosty day. While all goes well the hand remains a perfect machine, for it only has to grip the handle bars and the exhaust lift. The fourth type of grip, that of power only, is in use. But if the engine stops, it is almost impossible with chilled hands to undo the buckle of the tool bag or to turn the milled nut of the spanner, because the intrinsics are numbed. Power is there, but accuracy has gone.

This patient in Astley Cooper, then, has lost, probably permanently, the use of his right hand as an accurate machine, but thanks to good treatment and the absence of contractures it remains almost unimpaired as a powerful grasping machine, a fact which he will himself volunteer. His right course then is to train his left hand to the accurate movements, when his earning power should be very little affected, for the majority of people only use one of their two hands for this purpose. The loss of ulnar sensibility, even if it remains permanent, is not a great disability, whereas the loss of median sensation is almost a bar to any real use of the hand. If the thumb and first two fingers are insensitive a man no longer feels that his hand is part of himself, and he will not use it.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

"Herpes Zoster and Varicella."

DEAR SIR,—I can supply a few figures on the inter-relation between chicken-pox and shingles, but I am afraid they do not furnish any very conclusive answer to Dr. H. M. Stewart's query. From 1911 to present date (exclusive of two years when I was away on active service) there were 16 cases of shingles among the boarders at Clifton College. Ten of these had not had chicken-pox, while six had had the disease before coming to Clifton. I have only once seen an epidemic of chicken-pox which was coincident with an appreciable number of cases of shingles, and that was in 1919, when, during a moderately-sized outbreak, there occurred six cases of shingles, only two of which gave a history of previous chicken-pox.—I am, yours faithfully,

J. M. FORTESCUE BRICKDALE.

Clifton.
August, 1920.

Rowing at Guy's.

DEAR SIR,—The revival of the Rowing Club of Guy's, and my old friend Sir George Savage's reminiscences, rouse me to plunge into old rowing memories of Guy's. I rowed four in the last or last but one "eight" of the '60's against Bart.'s, and it was much against my wish. I was told the day before the race that unless I rowed there would be no race. So, out of training and with no recent practice, I was installed at "4" (the late Mr. Davies-Colley was five), all the rest except stroke University (O. and C.) men whether rowing or not I could not say or see.

Mr. Cooper Forster had rowed bow of a Guy's four at Henley for the Stewards' Challenge Cup in 1846, and there is mention in Bell's Life of the account of Henley regatta in 1840, as follows:

"Among the boats on the reach were noticed the eight-oared wherry belonging to the Guards, the eight-oared gig of the Travellers' Club, the Magdalen Hall, cutter, the four of Guy's Hospital, etc."

On the occasion of my race in the sixties (I think '67 or '68), Mr. Cooper Forster promised me to be at the winning (to us it was a losing) post with a silver cup full of champagne, and I was to have first pull. He did and I did.

Being an old stroke, and feeling Bart.'s wash soon after starting, I took the privilege of looking at Bart.'s, and, to my surprise, saw an old antagonist, the late stroke of Queen's College (Oxon.) eight, whom I had never been able to bump.

He took the same old quarter of a length at the start, and he never let our stroke have it back.

In '62, when I first joined Guy's, I do not remember much boating. A year or two ago (of course, before the war), there was a very cheap house and garden to be acquired above the lock at Richmond, and it was in my mind to try for a Hospital Rowing Club, but instead I found coaching a young neighbour and his sister for the Sciff Club Championship more to my means, and their success led me to think there was a "bit of something in an old dog yet." Success to the revival.—Yours sincerely,

TOM BIRD.

United University Club,
Pall Mall East, S.W.1.
August 11th, 1920.

P.S.—

"Henley.
Guy's Club, London.
Berks.

Bow, I. C. Forster, 10st. 4lb.; 2, H. M. Gruggen, 11st. 7lb.; 3, W. Ferguson, 13st.; str., G. Cooper, 11st. 4lb.; cox, A. Poland.

They rowed a dead heat, and were subsequently beaten by an Oxford University Boating Club four."

A Case of Stokes Adams Disease.

DEAR SIR,—In your last issue you were kind enough to publish a case of Stokes Adams disease from one of the Clinical Wards. The man has since died, and I think that a few notes on the post-mortem findings might be interesting.

He died very suddenly with all the symptoms of internal bleeding.

At the autopsy about six pints of blood were found in the posterior mediastinum. No lesion of heart or aorta was found to account for this, and it has been suggested that there may have been a rupture of some small vessel, probably a bronchial artery.

The heart muscle showed diffused fibrous changes. There were no valve lesions except a slight roughening of the aortic cusps. The aorta was very atheromatous, and the liver large and in a condition of early cirrhosis.

Everything else was normal.—I am, yours etc.,

A. McKENZIE.

Guy's Hospital,
London, S.E.1.
August 16th, 1920.

Inoculation.

DEAR SIR,—May I make one or two remarks in connection with Dr. Bevan Brown's article "Inoculation." As one of the two medical officers giving the inoculation, I am naturally interested in the diagnosis of these cases. First it should be pointed out that the vaccine was T.A.B., and not anti-cholera, as stated.

The first obvious suggestion made for a diagnosis was a toxæmia due to the bacillus typhosus. Lethargy and gradual rise of temperature for a week agree with this suggestion, and no enteric symptoms would be expected as the organisms were injected direct into the system. No rose-spots were, however, observed in the survivors.

Another suggestion made at the hospital where the sixty sick were admitted was that the vaccine contained a diphtheroid organism, as the arms in some cases gave off large sloughs such as are described as having occurred before the days of antisepsis in cases of "hospital gangrene." So much was this opinion held that a throat swab taken from myself was examined, as far as I know without giving any positive information.

One does rather regret that the Army authorities, after pumping us for all the information we could give them, remain so reticent with regard to what they have found out. I should have thought there was very little doubt as to the pathogenic nature of an organism found in a vaccine, which, on injection, caused a morbidity of thirty per cent., and a mortality of three and a-half per cent.

We might at any rate be told to what class the organism belonged even if its actual identity be unknown.—Yours sincerely,

B. E. JERWOOD.

Hayne, Oakham,
Rutland.
August, 15th, 1920.

DEAR MR. EDITOR,—In reference to my article on Inoculation in the last issue of the GAZETTE, some further points should be added which I have only recently discovered from the medical officer in charge of the cases after they reached the shore hospital. The organism found in the vaccine bottle was a streptococcus of low virulence. Guinea pigs did not mind large doses of it. Swabs taken from the incisions in the arms gave gram-positive anærobes in large numbers near the site of inoculation.

In a few cases black sloughs formed on the arms and in one or two cases there was a suspicion of gas formation under the skin.

In conclusion, I would like to take this opportunity on the eve of sailing for New Zealand of saying goodbye to my friends at Guy's. I share the regret that everyone feels when the time comes to leave the Hospital. I owe more than I can say to the traditions, experience, and inspirations that this fine Hospital has given me, and I very much hope to be able to return from time to time to renew old friendships and to revive pleasant memories.

F. V. BEVAN BROWN.

The College, Guy's Hospital,
London, S.E.1.

The Prize Giving.

DEAR MR. EDITOR,—I was pained to read in the GAZETTE of 7th August your evident satisfaction at the suppression this year of the Garden Party associated in pre-war days with the Annual Prizegiving, and pleasure at the exclusive meeting of "Guy's men—staff and students."

But what about the old Guy's man? Most old Guy's men are gregarious folk, and look forward to such occasions as the Garden Party for pleasant reunions and like to bring their women folk to see the place where they have spent some of the best years of their life.

When you are an old Guy's man I think you will appreciate our point of view. If you practice abroad twenty years may easily elapse before your visits to the Old Country co-incide with a Biennial Dinner, and you will welcome an annual summer event when you may hope to meet old friends. No sir, I hope the Garden Party is *not* dead, and I am sure most old Guy's men hope so too.

By all means reserve the theatre for those most immediately interested, and abolish the cap and gown if you like, for they are only "frills," but for Heaven's sake leave us this chance of meeting our friends!—Yours very truly,

C. H. REINHOLD,
Major, I.M.S.

c/o Grindlay & Co.,
54, Parliament Street,
London, S.W.1.

[Major Reinhold has mistaken our meaning. We welcomed the dissociation of these two functions which are both admirable ones in themselves. The majority of the guests at the Garden Party have only a very partial interest in the Prizegiving, and their presence deters a large number of students from attending the only meeting at which the Staff get an opportunity of talking direct to the students. Old Guy's men are always welcome at the Hospital, and the date of the Prizegiving might well be published in advance in the GAZETTE to give them the chance of coming if they wish. There is much to be said in favour of the revival of the Garden Party, but not combined with the Prizegiving.—Ed.]

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Residents' Dinner.

The Residents' Dinner was held in the College Dining Room on Thursday, August 12th. After the toast of the King had been drunk, Mr. Kidman, the retiring President, proceeded to the election of his successor. Mr. H. W. Evans was elected President, and Mr. J. Gaymer Jones Vice-President. In proposing the health of the new President and Vice-President, Mr. Kidman said that he felt that it was an honour to himself to be followed by such a great son of Guy's, such a great athlete, and such a fine sportsman as Mr. Evans. Mr. Jones was another great Guy's man who would worthily uphold the traditions of the post to which he had been elected.

Mr. Evans, in replying, attempted to resign the post to which he had been called on the grounds that he had held it before during the war in 1914, but this was held to be an inadequate excuse. After thanking the Residents for his election, he expressed the hope that he would live up to the example set by his predecessor, also a son of Guy's —quite a big boy of Guy's in fact.

Mr. Jones replied in apologetic vein, saying that he felt that he was not the man for the position. Hitherto they had always had big men, like Mr. Kidman, men with pointed collars. The only time that he had ventured to put on a pointed collar he had been told that he looked a perfect fool. He proposed the health of Mr. Kidman and Mr. Bonar, the retiring President and Vice-President.

Mr. Kidman said that he was not capable of a long speech, but he tendered his thanks on behalf of himself and also of Mr. Bonar, who was unfortunately absent. It was a sad moment when one came to leave Guy's; yet no one ever really left Guy's completely. There was always so much Freemasonry among Guy's men. In the Army he had always found combatant officers proud to say that their M.O. was a Guy's man. He thought that the great thing about the teaching at the Hospital was that there was no spoon feeding. Men learnt and were not taught. In this respect he thought that the appointment of Surgical Ward Clerk was a most valuable one, and he thought that the Oxford and Cambridge men, although surprised at first at having to wash plates and make tea, realised the value of it. He asked everyone to drink the toast of the appointment of Ward Clerk, coupled with the name of Mr. Ogilvie as representing Oxford University.

Mr. Ogilvie briefly replied, and expressed agreement with what Mr. Kidman had said about Surgical Ward Clerks.

Mr. Tanner, being unanimously invited to speak on the suggestion of Mr. Glover, said that he had been at so many of these functions that he was sure that everyone must be tired of him. He was certain that they had found the right man to succeed Mr. Kidman. He was sorry in a way that Mr. Kidman was not going to stay on as a medical registrar, but he was confident that this was of his own choosing, and perhaps he was wise after all to eschew the slippery and disappointing paths of specialism. He thought that it was a fine thing that Mr. Kidman was joining the ranks of the general practitioners, who were, after all, specialists in everything. Another thing that gave him intense satisfaction was that his old friend, Mr. Frank Cook, was at last going to get his chance as an operator. One thing more he would like to say. He would like to see less Bolshevism about the place—less criticism and more loyal support of the Staff by all the men. He looked to the qualified men to set an example in this direction.

William Gray, appearing at this moment, was then invited to speak. He spoke eloquently of the part that Guy's men had played in the war, and expressed his great pleasure at seeing so many old friends return after their prolonged absence. He asked everyone present to drink to the health of Guy's, which was accordingly and enthusiastically done.

Mr. Cook followed, and after Mr. Sawday had briefly replied to the toast of the off-going Residents, proposed by Mr. Hirsch, the proceedings adjourned to the Residents' Room, where music, vocal and instrumental, assisted to terminate a highly successful evening.

A Case of Acute Osteo-Myelitis of the Humerus.

The following are the notes on a case recently admitted to the Surgical Wards.

F.M., a girl of nine years of age, was admitted into Lydia Ward on the 13th August, 1920, with a diagnosis of acute osteomyelitis, broncho-pneumonia and pericarditis.

She was apparently quite well until the 9th inst., when she fell down in the street and came home complaining of pain in her right arm. On the 11th she became rapidly worse and had to stay in bed, and on Friday came to the Surgery and was immediately taken in. On admission she was obviously very ill, and suffering from a profound toxæmia. Her temperature was 102·9, pulse 170, and respiration 65.

There were diffuse râles and areas of dulness over her chest, her heart was enlarged, and a harsh rub could be heard over it. Her right arm and especially the upper two-thirds was swollen, brawny and tender. The swelling extended over the shoulder joint, but the absence of any marked limitation of movement seemed to exclude the presence of a

suppurative arthritis. It was evident that any extensive operative procedure was out of the question, and as soon as possible she was given gas and oxygen, and an incision having been made down to the humerus, a quantity of pus was released. A drain was inserted, and she was taken back to bed.

She became delirious shortly after the operation, and gradually becoming weaker, died at 8 a.m. on 14th inst.

A post-mortem examination was made on the same day, and was reported as follows:—

The glands at the bifurcation were enlarged and acutely inflamed; pleurisy of both lungs. The heart was enlarged and covered with a dry exudate. There were small recent infarcts in the heart muscle, and the valves were covered with small recent vegetations. There were multiple infarcts in the lungs, and a few small infarcts in both kidneys.

A local examination of the right humerus showed that the condition was an acute suppurative periostitis, the periosteum of the upper two-thirds of the bone being stripped up exposing dead bone. The epiphysis and the joint were unaffected, and there was no pus in the medulla.

E. BIDDLE.

Reviews.

Gonococcal Infection in the Male. By Norman Lumb, O.B.E., M.B., B.S. London. (Messrs. John Bale, Sons & Danielsson, Ltd.) price 25s.

The literature of gonorrhœa is already so voluminous that one approaches a new book on this pest of humanity with a certain amount of prejudice. It is almost bound to be a recapitulation of what has been said and done elsewhere. But the author in this respect is fortunate. If to him is addressed the famous question "What did you do in the Great War, daddie?" he can reply with truth "I attended 50,000 gonorrhœal soldiers, my son, and my name was only slightly less well known among the troops than that of the Field-Marshal-Commanding himself." In the face of such vast experience the voice of criticism is of necessity somewhat stifled.

The author deals with his subject in a thorough and systematic manner, and the result is an excellent work of reference alike for the student and the practitioner. It is interesting to note that he recommends the filling of the bladder, and consequent irrigation of the whole urethra, from the first day of the fully developed disease, without waiting for the extension of the gonococcal infection to the posterior urethra, and he claims that cases so treated do much better than those in which a period of three to four weeks is allowed to elapse before posterior irrigation is commenced. In England at any rate this teaching is unorthodox, our leading authorities maintaining that it is the ideal way in which to infect a previously healthy posterior urethra. From his own experience the writer entirely agrees with the author that this theory is not borne out by practice, and he has invariably found early posterior irrigation to be the best method of cutting short an acute attack.

For the severe pain felt in the hyper-acute form of epididymitis aspiratory puncture is recommended, the method being to thrust a needle attached to a syringe into the lower pole of the epididymis in the direction of the globus major, and then draw off 1 to 2 c.c. of fluid. The author claims that the intense pain disappears in half an hour after such a puncture, and that soon afterwards the patient feels quite comfortable. A method which brings such speedy relief to the agony of this very distressing complication is certainly worthy of thorough trial.

One is not very impressed with the author's advocacy of vaccine-therapy. He states that one of the objects of its exhibition is to forestall complications. But the whole question of the use of vaccines in gonorrhœa is still very much *sub judice*. The duration of the negative phase following an injection is not properly understood, and Kidd even affirms that in the acute stage of the disease the negative phase is not succeeded by a positive, and that therefore a vaccine actually does harm. As regards chronic gonorrhœa, prostatic massage is part of its routine treatment, and, if vaccines have any therapeutic value here, as good a way as any to give them is to massage the patient's prostate and seminal vesicles, when he would be auto-inoculated with his own vaccines.

The best part of a good book is that which deals with the urethroscope, and the importance of every patient being urethroscoped before his discharge as cured is insisted upon. It would be interesting to know how many divorce cases and how much chronic ill-health among women are caused by closed and infected glands of littré. Unless these are detected and destroyed with the operating urethroscope they may not burst till months or years after the original infection, with the result that if the patient has married in the meanwhile his unfortunate wife is certain to be infected. By this time the husband may have forgotten about the indiscretion of his earlier years, and his wife very naturally gets the blame for his recently developed urethritis. And when once gonorrhœa has settled as a parasite upon both parties to the marriage-contract, it is only a step to the divorce court. Reformed rakes may make the best husbands, but not unless they have been urethroscoped. The instruments described are those of Wyndham-Powell, Luys and Buerger, and there is a series of beautiful coloured plates illustrating the urethroscopic appearances of the normal and pathological urethra. These are so clear and excellent that the only criticism which one can make against them is that they may induce the beginner to think that urethroscopy is a cut and dried subject which can be learnt from a book instead of one which has to be painstakingly acquired from the living subject.

There is a chapter on that remarkable skin complication known as keratodermia blenorrhagica, though it must be admitted that its accompanying illustrations do not compare with the wonderful case which, through the courtesy of Dr. Fawcett, it was the writer's privilege to see quite recently in Stephen Ward, in which case, by the way, no source

of gonococcal infection could be found! Stress is laid on the importance of using Kollmann's dilators to ensure the rapid cure of folliculitis in its various stages, and of soft and hard infiltrations, and the details of the manipulation of these useful instruments are fully described.

In conclusion the author is to be congratulated on the production of a really excellent book, which is a model of sound and exhaustive investigation, and indeed a contrast to the old empirical methods of treating gonorrhœa. If it achieves the circulation which it deserves, and if its lessons are taken to heart, much will have been done to effect a real cure of sufferers from this troublesome and disheartening disease; and, incidentally, we shall see fewer poor old men coming up to the Front Surgery with retention of urine, to be poked at with catheters by dressers and House Officers.

Diagnosis of Bacteria and Blood Parasites. By E. P. Minett, M.D., D.P.H., D.T.M.& H., M.R.C.S., L.R.C.P. (Messrs. Ballière, Tindall & Cox, London) 3rd edition, 1920; price 4s. 6d. net.

The author of this small book is in an unique position in that he does not profess to cater for the examination candidate. In his preface he claims that his book is a "pocket laboratory companion," and his claim is well justified by the contents. All the important bacteriological methods are mentioned and the steps taken in the identification of bacteria are clearly and systematically tabulated. Such bedside operations as Lumbar Puncture, the collection of blood for a Wassermann, and Blood Culture are briefly but lucidly described. To the practitioner who finds time and opportunity to be his own bacteriologist this book will prove of no inconsiderable value provided that his medical education has included a thorough grounding in the necessary laboratory technique, for it is not, and is not intended, to be a work from which the doctor or student can learn his subject. It is the duty of the critic to criticise, but we do not wish to detract from the merits of Dr. Minett's work if we mention the omission of Dreyer's Standard Agglutination Method. It proved of use during the war and is too little used outside Dr. Dreyer's own laboratory. And why is it that Bie's stain for the Klebs-Loeffler Bacillus is mentioned in so few of the bacteriology books? But for all this Dr. Minett's book is an admirably practical piece of work, and, considering its very moderate price, should appeal to a large and appreciative public.

Selected Lectures and Essays including Ligaments their Nature and Morphology. By Sir John Bland Sutton (Messrs. Wm. Heinemann (Medical Books), Ltd.); price 15s. net.

When Sir John Bland Sutton retired from the Visiting Staff of the Middlesex Hospital history relates that he presented a copy of his latest book to each of his students. Their lot is indeed to be envied, for the work under review abounds in good things. We read in a footnote to page 1 that the first edition appeared in 1887, this being a fourth with much re-arrangement and some new matter. This latter is of a very varied and extremely interesting character and contains information suitable for discussion with examiners, old ladies, clergymen, small boys and other inquisitive persons. He begins the new matter with a dissertation on gizzards and counterfeit gizzards. Then follow two chapters on urinary calculi and new ulcers for old. The searcher after the rare and curious cannot fail to be fascinated by his accounts of injuries to the heart and missiles as emboli and hermaphroditism. The gynæcologist has chapters on ectopic gestation and errors of development of the embryo, the naturalist one on the antlers of fallow deer. His account of the history of circumcision is most interesting, as is also his next chapter on atrocities of war, a gruesome story. The traveller is catered for in a chapter on bull-fighting and pulque drinking in Mexico. We learn that this national drink "has a peculiar, sour and offensive odour, resembling that of rotten eggs or cheese or a combination of rotten eggs and sour milk." Small wonder that Mexico is a land of unrest! There is a very interesting account of medicine in the Bible with a picture of Punch's dog Toby at the finish, but probably the most read chapters in the book will be the final six, which deal with convoying in the North Atlantic during the late war. Sir John crossed from America to the United Kingdom in 1917 or 1918 in a convoy and his account is very good reading, especially to such as have served afloat. When one his finished reading the book one is astonished at the extraordinary erudition of its author. It may indeed be well said of Sir John *Nihil tetiget quod non ornavit.* Each subject is described by one who is master of that subject. The book is indeed fascinating, and is an ornament to any library. It is just the thing for a holiday to read in the train or help to pass a wet day.

Inter-Hospital Cup Winners, 1919-20.

Rugby Football	...	Senior—Guy's. Junior—Guy's.
Association Football		Senior—Guy's. Junior—Guy's.
University of London Cup—Guy's.		
Cricket	... ...	Senior—St. Thomas's. Junior—Guy's.
Athletics	... ...	Guy's.
Univ. of Lond. Cup		(Guy's / King's) Joint holders.
Hockey	... ...	Senior—St. Thomas's.
Swimming	... ...	Guy's.
Rowing	... ...	Guy's.
Tennis	... ...	Senior—St. Bart.'s. Junior—King's.
Shooting	... ...	Guy's.
Boxing	... ...	London by two points, due chiefly to the fact that Guy's only had five competitors for the seven events, but won four competitions—bantam, light, feathers, and middle weight.

Cricket.

Semi-Final Junior Inter-Hospital Cup.

GUY'S 2ND v. MIDDLESEX 2ND.

Played at Honor Oak Park on 20th June. We opened rather badly, losing the first two wickets for 25. Then Harris (40) and Mackay (44) proceeded to make runs with great ease, and carried the score to 100 before being parted. Slater (47) and Thomas (46) then treated us to another exhibition of run getting, and upon Slater's dismissal Pengelly played delightful cricket for 63, scoring runs freely all round the wicket. The innings closed for 312 after Payne had contributed a nice 21.

Middlesex lost their first wicket for 0 to Fauré. The Guy's fielding was good, and Duncan kept wicket very well, no extras being registered. The bowling of Bowen was excellent, as his analysis, 6 for 14, shows. With the exception of Chissell (17) no batsman reached double figures, the innings closing for 37. Scores:—

Guy's 2nd.

R. F. H. Duncan, b Hasler	5
D. C. Eglington, b Hasler	1
H. A. H. Harris, b Levy	40
A. L. Mackay, l.b.w. Levy	44
H. Slater, b McKinnon	47
J. D. S. Thomas, b Hasler	46
R. Pengelly, l.b.w. Hasler	63
T. M. Fripp, b Hasler	8
J. C. Fauré, c Hasler b McKinnon	5
F. R. Payne, c Riches b Hasler	21
C. G. Bowen, not out	7
Extras	25
Total	312

Middlesex 2nd.

Hasler, b Fauré	0
Chissell, b Fauré	17
Hutton, b Bowen	9
McKinnon, b Bowen	0
Wilson, b Bowen	2
Gainer, c Slater b Bowen	7
Grieg, not out	1
Levy, b Bowen	0
Wiggins, b Fauré	0
Hegall, run out	0
Riches, b Bowen	1
Extras	0
Total	37

Final Junior Inter-Hospital Cup.

GUY'S 2ND v. ST. THOMAS'S 2ND.

Played at St. Bart.'s ground, Winchmore Hill, on July 15th. Losing the toss, we fielded first, and for about one and a-half hours fielded only ten men. However, we started very well, getting rid of three of their best batsmen for only 14 runs through good catches in the slips by Bowen and Mackay (2).

Churchill, who now came, started hitting beautifully, and the score rose quickly. St. Thomas's were all out just before lunch for 161, Churchill (65) and Attab (35) being the best scores. Churchill played a magnificent innings, making runs quickly just when it looked as if a "rot" had set in.

We also started badly, losing three wickets for 26, but Mackay and Duncan improved matters, taking the score to 59. Mackay was now getting properly set, and making runs quickly. The fifth wicket did not fall till 96, and then Eglington stayed until the score reached 147. Mackay all this time had been batting splendidly, and he and Pengelly hit off the remaining runs. There is no doubt that Mackay won the match for us. Playing with confidence all the way through, he gave heart to the batsmen who followed him. He went in No. 4 and was seventh out, making an invaluable 98. The next best scores were D. Fripp (19), Eglington (18), Duncan and Pengelly (16). Bowen, four for 36, was the most successful bowler. Scores:—

St. Thomas's 2nd.

H. Mayer, b Faure	13
J. Fredman, c Bowen b Fauré	1
J. H. Toggart, c Mackay b Bowen	6
B. B. North, c Mackay b Bowen	0
D. G. Churchill, c Payne b Bowen	65
H. S. Garson, b Payne	3
G. A. B. Walters, c Eglington b Payne ...	6
E. E. E. Attab, b Pengelly	35
J. R. McMahon, l.b.w. Pengelly	0
H. Spencer Davis, b Bowen	3
H. Slaughter, not out	2
Extras	27
Total	161

Guy's 2nd.

T. M. Fripp, c Maber b Fredman	19
H. Slater, b Toggart	2
H. A. H. Harris, c Garson b Fredman ...	2
A. L. Mackay, b Slaughter	98
R. F. H. Duncan, c and b Fredman	16
J. D. S. Thomas, c Churchill b Toggart ...	7
D. C. Eglington, c Toggart b Slaughter ...	18
R. G. Pengelly, b Slaughter	16
J. C. Fauré, not out	3
Extras	9
Total (for 8 wickets)	190

F. R. Payne and C. G. Bowen did not bat.

GUY'S 2ND v. BEDDINGTON 2ND.

Played at Beddington on . We won quite comfortably by 206 for 6 declared to 91. Mackay (60), Thomas (31 not out), Rowbotham (27) and Slater (25) were the most successful batsmen. Pengelly, Bowen and Payne bowled well.

GUY'S v. CYPHERS.

Played on Thursday, July 22nd, at Beckenham. Cyphers fared none too well before lunch, losing five wickets for 36. After lunch, however, the tail wagged, and the score was carried to 231—chiefly owing to a fine fighting innings by A. J. Whyte. The Hospital could do nothing right, and collapsed badly, the last five wickets falling for 12 runs. Scores:—

Cyphers.

F. J. Wardle, run out	5
N. P. Andrews, l.b.w. b Skeels	11
A. C. H. Back, c Shaw b Schalkwijk	0
P. B. Wise, c Shaw b Skeels	8
L. A. Simmonds, b Schalkwijk	2
A. J. White, c Shearar b Hewetson	45
A. R. Beardwell, c Sub b Hewetson	25
W. R. Beardwell, c Skeels b Biddle	47
A. Johnson, c Shearar b Schalkwijk	34
R. Holloway, not out	21
F. Mann, l.b.w. b Biddle	8
Extras	25
Total	231

Guy's.

G. D. Shaw, c Whyte b Simmonds	0
J. Van Schalkwijk, b Beardwell, W. R. ...	21
T. Wooldridge, b Beardwell, W. R.	4
L. B. Helder, b Simmonds	6
R. F. H. Duncan, b Beardwell	5
G. L. Shearar, run out	18
J. C. Hewetson, b Beardwell	0
R. C. Pengelly, c and b Simmonds	0
F. J. Biddle, not out	1
P. B. Skeels, b Beardwell	0
L. C. Willis, c Johnson b Simmonds	4
Extras	3
Total	62

GUY'S v. PRIVATE BANKS.

Played at Catford on August 7th. Batting first, the Hospital put together 235 for the loss of three wickets in two hours, thanks to capital innings by Wooldridge and Vincent Brown. Both hit finely, and Wooldridge included two sixes and a five, though he was a trifle lucky throughout. The Banks were dismissed for 175 with a quarter of an hour to spare. Scores:—

Guy's.

G. Curle, b Skinner	9
G. L. Shearar, c and b Skinner	10
T. Wooldridge, not out	104
C. Vincent Brown, c Legg b Ingersoll	100
Extras	12
Total (for 3 wickets dec.) ...	235

L. B. Helder, V. R. Estment, J. D. S. Thomas, D. Eglington, R. Van Guens, F. R. Payne and J. H. Winston did not bat.

Private Banks.

C. E. Melville, c and b Payne	10
E. T. Legg, b Wooldridge	32
H. W. Skinner, run out	15
C. R. Ingersoll, b Payne	0
P. K. Broomfield, l.b.w. b Curle	41
R. W. Thomas, st. Brown b Helder	13
C. L. Penman, run out	2
E. J. Morris, c Eglington b Payne	31
W. A. Smith, b Wooldridge	11
F. D. Hopkins, c Brown b Wooldridge ...	7
A. J. Smith, not out	2
Extras	11
Total	175

GUY'S v. "PAST."

Unfortunately this game was spoilt by rain. The Hospital, batting first, scored 114 for the loss of only one wicket before lunch. Play after lunch was stopped after the addition of 10 runs. All thanks are due to Dr. Hancock for collecting the "Past" at very short notice. Scores:—

Guy's.

E. H. Muir Smith, b Montgomery	4
L. C. Willis, not out	42
T. Wooldridge, not out	75
Extras	3
Total (for one wicket)	124

Change of Address.

Lieut. L. Lyne, I.M.S., c/o Messrs. Grindlay & Co., Bombay.

H. L. Peregrine, Surgeon, R.N., H.M.S. "Hood," c/o G.P.O.

Lancelot Horsley, 48, Cotswold Road, Westcliff-on-Sea.

C. F. Pedley, Winsley Sanatorium, near Bath.

Birth.

HORSLEY.—On July 21st, at Westcliff-on-Sea, to Grace, wife of Lancelot Horsley, M.R.C.S., L.R.C.P., a son.

Marriage.

COVELL-MACLEOD.—On the 6th August, at St. James' Church, Westend, by the Rev. B. S. Aldwell, B.A., Captain Gordon Covell, Indian Medical Service, younger son of Mr. and Mrs. E. L. Covell, 1, Gloucester Road, Finsbury Park, N., to Oona, youngest daughter of Colonel Kenneth Macleod, K.H.P. (I.M.S. retired) and Mrs. Macleod, Duncaple, Westend, Southampton.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

SOME time back we announced the probability that the Clubs' Union subscription would have to be raised to meet the increased charge upon their resources brought about by the general rise in prices. The same cause, combined with the proposed quarterly issue of the Guy's Hospital Reports, has contributed to the necessity, which has now arisen, of increasing the price of the GAZETTE. The price of individual numbers of the GAZETTE will shortly be raised from 6d. to 9d. with a corresponding rise in the annual subscription rates. This step is being taken with extreme reluctance, but at the same time it is confidently anticipated that all Guy's men will welcome the new arrangement of issuing the Reports and will not grudge the extra pence for their GAZETTE, especially when they consider that the rise in price has been so long deferred in spite of an increaesd cost of production which has been in operation for many years. The only way to limit further increase is a maintenance of that almost universal support which has been given to the GAZETTE by Guy's men in the past. We would further suggest that the interest and scope of the GAZETTE would be greatly enhanced if old Guy's men, especially those in general practice, would contribute to its pages on a more generous scale than has been their custom in recent years. The work at a large general hospital leaves a man in many ways poorly equipped for meeting the numerous problems and difficulties peculiar to general practice. We should like to think that a student could, by reading his GAZETTE, get a more intimate acquaintance with those aspects of general practice which are not adequately dealt with in his hospital training. There is always a tendency after a few years spent in the wards to regard, for example, the differential diagnosis of dyspeptic symptoms as lying solely between peptic ulcer and carcinoma ventriculi merely because the majority of cases admitted to the wards for those symptoms turn out to be one or other of these two conditions. Casualty work, the opportunities for which are so admirable at Guy's, is a good corrective, but reports of cases actually seen in general practice would be a valuable addition. We do not wish to attempt to confine intending contributors solely to the ordinary hum-drum cases, but a few of these, together with others of greater scientific and clinical interest would help to fill a gap in the curriculum which has been more or less present since the days of apprenticeships died out.

THERE is still a great deal of opposition to that State Aid for Hospitals which we mentioned in the last GAZETTE. In the financial straits in which all hospitals find themselves at the present time it is most important that the whole question of public grants to hospitals should be carefully considered and the arguments for and against thoughtfully reviewed. The first and perhaps most obvious argument against State Aid is that a State grant would have an undoubted deterrent effect on the regular subscriber. He would feel that his money was better spent in supporting institutions in which the State had no financial interest, with the result that the State would be left to provide the hospitals with their entire incomes except that part which might be derived from endowment. If this were the case we should feel some sympathy with the opponents of State Aid, for the position of an unendowed hosptial would become little short of that of a State-owned one, and that is a situation for which, at present, few of us are prepared. It is not uncommon for philanthropists to subscribe a sum to a fund on the condition that a certain numbers of others will subscribe a similar amount. This principle could easily be applied to the contributions of the State to the voluntary hospitals. The State would promise to contribute £1, or any sum that was considered reasonable, for every £1 that was raised by voluntary subscription. So far from acting as a deterrent this system would have a stimulating effect on private subscriptions, inasmuch as the private subscriber would have the satisfaction of knowing that his contribution of £1 really meant £2 to the hospital. Moreover, the subscriber of small amounts—men and women of the "new poor" class—would find it worth their while to support the hospitals to the utmost of their means as an insurance against serious illness.

There is, however, a further argument used against State Aid to Hospitals. It is said that public grants are invariably accompanied by conditions and are hedged around with rules and troublesome regulations. There is certainly some truth in this, but no public body is likely to contribute large sums of money without having some control over the way in which it is to be spent. It would be unreasonable if they did so. But the hospitals, even on the voluntary basis, are to some extent the servants of the Public and the Government are the representatives of the Public. Is it really so intolerable to allow the Public, upon whose generosity (and pathology) the hospitals are, and would still be, so dependent, some say in how the money they subscribe is to be disposed of? Probably the thought that is uppermost in the minds of those members of the profession who are responsible for medical education is that some future, and possibly Labour, Government would interfere with the educational opportunities of those hospitals to which a medical school is attached. Personally we can see no evidence that the class who may be considered the probable electors of a Labour Government resent the teaching facilities which they afford when admitted into the wards of a teaching hospital. And even if some did resent it, it ought not to be difficult to convince them that the widest possible scope for teaching is of vital importance to the health and efficiency of the Nation. Wherever there is ill feeling amongst the working classes about this matter there is also misconception which could be easily removed if the responsible persons would take the trouble to educate the Public. Education is the only sound foundation stone for the Temple of Social Progress.

THE commencement of the October term in a few weeks' time will see the Physical Society

resuming its usual winter programme. We recall the Society's activities during the past year with a certain amount of dissatisfaction. In the first place, the admirable inaugural address by Sir William Hale-White was delivered to a deplorably meagre audience consisting mainly of Residents and other qualified men. Secondly, the clinical and other meetings were equally badly attended; and finally, the discussions, with a very few exceptions, were usually confined to the qualified and more senior men present. Moreover, it was always the same men who took part in each debate. We hope that this state of affairs will not be allowed to continue during the coming year. The remedy lies in the hands of the students in the wards, of whom, according to all reports, there should be a fair number by October. Last year there were so few men, and those few so busy, that it was naturally difficult to secure large attendances. Now that these difficulties have been removed there should be no trouble in getting full meetings, and if there is a repetition of last year's failure in this respect it will reflect sadly on the men now working in the wards. There may be some men who have only recently started in the wards and who have never attended a meeting of the Physical Society. To these, and indeed to all, we would first of all insist that the Society is the *Pupils'* Physical Society. A stranger attending one of last year's meetings might easily have mistaken it for a Residents' or Registrars' Society. We have no intention, and certainly no desire, to deter Registrars, Residents, and other qualified men from attending the Society's meetings. We welcome their presence and hope that there will always be some senior men to direct the discussion into fruitful channels and to clear up difficult and doubtful points. But we do urge the student members to remember that it is *their* Society and that it is their duty to do most of the talking.

The opportunities offered by the Physical Society for acquiring a sound knowledge of Medicine, Surgery, and Pathology are unequalled. The Clinical evenings are the natural complement of ward teaching and often serve to clear up a hundred and one difficulties and misconceptions which have arisen in the course of the usual routine of study. We hope that all students working in the wards will realise that a Physical Society meeting is one of those numerous educational advantages peculiar to our Hospital, and that to miss them is to miss a great and valuable tradition which has been handed down to us by Astley Cooper, Bright and Addison and the other men whose names have built for Guy's its reputation as a great Medical School.

THE long overdue renovations to the College Dining Room have at last been commenced and the Smoking Room is being used as a temporary dining room. This latter room is a much more tolerable place, since it was repainted in the Spring, and one advantage of using it as a dining room is that the case of Cups becomes much more conspicuous. We have always thought it a mistake to put this case in a room which is only frequented by a comparatively small number of students, and into which no visitors or members of the Staff ever go. Surely it would be better to give this case a position more worthy of its contents. The Athletic Shield is now in the Dining Room. Why should not the Cup case also be housed there? If the case was modified so that it had four glass sides and was placed in the centre of the Dining Room on, or in place of, the very inartistic piece of furniture which at present occupies that position, not only would its contents be displayed to much greater advantage, but many more people would be able to see it. After all, we have

some reason to be proud of our Cups and it is hardly reasonable to give them so inconspicuous a situation as they at present occupy in the Smoking Room.

Pass List.

FIRST EXAMINATION FOR MEDICAL DEGREES, July, 1920.

C. B. Andrae.
P. C. Bennison.
*H. E. Blake.
E. W. Bostock.
H. N. Collier.
Llewellyn Davies.
G. R. Ford.
H. J. Fuller.
A. S. Gough.
R. A. Nash.
R. G. Nethery.
T. C. Pain.
A. B. Plant.
A. W. Riddolls.
*W. F. Roper.
H. J. Selby.
James Sellick.
D. A. Skan.
T. P. Spurrell.
L. A. S. Trott.
H. K. Williams.
R. G. Williams.
C. L. Worthington.
J. C. Young.

*Awarded a Mark of Distinction in Physics.

SECOND EXAMINATION FOR MEDICAL DEGREES, Part I., July, 1920.

M. T. Aung.
*D. H. Berry.
H. G. Close.
J. C. G. Dickinson.
R. D. Gross.
C. S. Hallpike.
H. N. Hearle.
C. Ive.
J. G. Kingsbury.
R. E. Lane.
N. L. Lloyd.
F. Marsh.
W. A. Mill.
E. E. Neser.
E. C. Seward.
N. Taylor, B.Sc. (War.)
H. D. Wyse.

*Awarded a Mark of Distinction.

Conjoint Board.

FIRST EXAMINATION CHEMISTRY, PHYSICS AND BIOLOGY, July, 1920.

G. S. Landon.
††C. F. Morrison.
E. H. J. Berry.
††W. A. A. Collington.
‡V. L. Fisher.
**C. L. Fraehlisch.
**S. F. Durrans.
*E. Bowen Jones.
*A. H. Lipschitz.
†C. E. Keast.
‡D. H. Couch.
‡F. A. Wilson.
‡W. Tressidder.
‡J. P. L. Davies.
‡L. F. Davies.
‡S. G. R. Pimm.
H. Van der Post.
T. St. J. H. Silvester.
**C. C. Williamson.
*‡H. E. Filmer.
††H. B. Davies.
†J. S. Jacoboz.
*J. Maingard.
‡H. J. Walters.
‡R. A. Norman.
‡R. H. El Sawry.
‡D. F. Johnstone.
‡J. J. Laws.
*W. H. Dowell.
**B. M. Francis.
*B. Horwitz.
**A. C. Taylor.
**D. C. Drake.
†B. P. Jones.
*E. I. Liberman.
†J. M. Hurwitz.
‡H. G. Davies.
‡T. J. Williams.
J. M. Van Schalkwijk.
R. R. McKenzie.
**G. W. Murray.
**J. K. Pescod.
‡H. C. Lee.
‡F. J. Levy.
‡D. R. Martin.

**Chemistry and Physics only; †Physics only; *Chemistry only; ‡Biology only.

FINAL EXAMINATION, July, 1920.

Medicine.

M. F. Ismail.
A. El H. Kassem.
E. T. Lloyd.
E. F. Wilson.
D. J. P. O'Meara.
B. M. Tonkin.

Surgery.

W. Remington.
L. Moss.
B. M. Tonkin.
E. E. D. Gray.
G. K. Reeves.
E. J. Crisp.
C. I. G. Gill.
W. D. Doherty.
F. W. Crook.

Midwifery.

L. K. Watson.
P. L. Richardson.
N. Sidky.
O. T. Maclaren.
E. C. Faraker.
I. Rosenberg.
J. B. Gregor.

PRELIMINARY SCIENCE, L.D.S.

H. Metheringham.
G. A. Lawson Brown.
†A. R. H. Bennett.
A. Clarke.
N. S. Campbell.
D. J. Baker.
T. Vallange.
W. O. Sims.
R. G. Pengelly.
R. S. de Bruyn.
*C. V. T. Baugh.
B. J. Cilliers.
J. F. Reynolds.
E. Z. C. Pearson.
D. A. Parsons.
†J. R. A. Moore.
*H. Radin.
L. C. Willis.
J. F. Allen.
A. J. Beitz.
†M. C. Hart.
*M. Rubenstein.
*S. G. French.
†A. V. Goodson.
†F. A. Sampson.
A. D. Miller.
†H. V. R. Sellers.
*F. G. Davies.
†C. M. R. Van der Merwe.
*J. E. B. Smith.
F. R. Payne.
†W. E. Silver.
†S. Eidinow.
†R. H. Muller.
*L. P. Tupling.
†J. P. Hartman.
†R. C. Ballard.

*Chemistry only. †Physics only.

Change of Address.

H. C. Rook, M.B., 41, Watergate, Grantham, Lincs.

W. A. Ellington, 27, Rue Louis Fiteca, Woluivé-St. Pierre, Bruxelles.

Appointments.

A. Atkins Greenwood, M.B., B.S. (1) to be Divisional Surgeon to Police of "Y" Division, Hornsey; (2) to be Medical Referee for Hornsey under Ministry of Pensions.

The Selection of the Anæsthetic.

CLINICAL LECTURE BY FRANCIS E. SHIPWAY.

GENTLEMEN,—As this is a big subject and it is impossible to discuss it as fully as I should wish in the limited time at my disposal, I propose to talk mainly about general principles and also to give my views, as the result of experience, as to the proper anæsthetic to be used not only in the induction but in the maintenance of anæsthesia in certain special cases. There is a wide difference of opinion, and there are so many and diverse factors to be considered in the choice of anæsthetic in these cases that it is unjustifiable to be dogmatic. The position is rendered the more difficult from the fact that we have at the present day several different anæsthetics and combinations as well as a number of different methods of administering them. You will probably be more interested in the simple methods than in those which appeal to the expert, and will approach his problems from a different standpoint; but it is right that you should know something of the factors which enter into their solution.

In a Medical School, such as this, which draws students from all parts of the world and sends them, when qualified, to all parts of the world, the influence of climate upon the selection of the anæsthetic cannot be ignored. It is obviously of very little use for a man who is going to practise in a hot country to attempt to adopt the methods which he found most suitable for this country. He will have to use the anæsthetics and methods which experience has shown to be the most successful, and to adapt his ideas and knowledge to the climate in which he is working.

Your first and most important consideration in selecting the anæsthetic must be the safety of the patient. Ether, therefore, is the routine anæsthetic. It is by far the safest anæsthetic for the healthy adult who is to undergo a major operation, that is, for the patient whose condition requires deep anæsthesia and prolonged anæsthesia. There was formerly much controversy as to whether ether was not so frequently followed by pulmonary complication that if the after-results were taken into account, as well as the immediate results, its death-rate was at least equal to that of chloroform. Neither statistics nor experience were, I believe, in favour of this view. I am quite convinced that it is not true of modern practice, in which much improved methods of administration are noticeable. The incidence of bronchitis and broncho-pneumonia is small, and although there is a tendency in the surgical wards of most hospitals for the student to overlook any post-operative condition which is not immediately connected with the wound and to label as pneumonia cases of massive collapse of the lungs, he cannot fail to have been struck by the rarity of serious pulmonary sequelæ. Some abdominal cases following deep ether anæsthesia are what is frequently called "chesty," but it will be found that the same condition not infrequently results from the use of C.E. or chloroform, whilst pneumonia is not unknown after spinal anæsthesia. They are post-operative rather than post-anæsthetic. Therefore, for major operations and healthy subjects choose ether. I assume that atropine is always given.

With regard to induction, knowing that induction with ether is slow and difficult, you will be inclined to choose some anæsthetic or mixture which is more pleasant to inhale, more rapid in its action, and more easy for you to administer. "Gas and ether" demands constant practice. I do not recommend it. Open ethyl chloride is soon learnt. This anæsthetic is easily and rapidly inhaled. It is a very good agent for induction, and is safe. Or you can begin with C.E. This is also an excellent introduction to ether, and is also safe, provided that you do not wait too long before you start dropping on ether. The time to do this is at the beginning of the stage of excitement. Students are liable to forget this essential precaution. They should remember that induction with C.E. or chloroform is never absolutely safe if it is given throughout the stage of struggling and breath-holding. However skilled the anæsthetist is, however long he has been administering chloroform, he always runs a risk if he uses it throughout the conduct of anæsthesia, for death from ventricular fibrillation—although very rare—may occur, and occurs without warning. The inexperienced anæthetist also subjects his patients to the risk of death from overdose by pressing chloroform upon him when he is struggling and holding his breath. No hos-

pital has a faultless record in this respect, and no expert anæsthetist will be found at the present day who is not fully alive to this danger. In changing from C.E. or chloroform to ether it is advisable to change the mask. The gauze retains a certain quantity of chloroform which is rapidly absorbed by the deeper breathing of ether, and is less readily eliminated owing to the semi-open nature of "open ether." If, as is often the case, it is not possible to change the mask, keep the method as open as possible for the first two minutes or so of the ether anæsthesia. By this time the chloroform will have evaporated, the anæsthesia will be one almost entirely of ether, and the open method can be converted into the semi-open.

I wish you to realise that although ether is the safest anæsthetic, it is highly unscientific to give more of it than is necessary to obtain the result which you require. The mistake is frequently made, even by experienced anæsthetists, of regarding ether as an innocuous drug. They are hypnotised by the "safety" of ether and so dominated by the evil tradition of absolute, death-like immobility of the patient that they are satisfied so long as respiration and pulse continue. The fact is overlooked that the severity of the after-results is in direct proportion to the depth of anæsthesia. The patient with varicose veins is anæsthetised as deeply as the patient who is being operated on for duodenal ulcer. Much of this unhappy overdosage is also due to the teaching of text-books which fail to impress upon the student its disadvantages and its evils, and some is due to the forgetfulness of the principle of adapting the dose of a drug to the patient. Further, prolonged deep anæsthesia may lead to exhaustion. It is true that in the moderately healthy patient this risk is small, but in weakly subjects or subjects with fatty or diseased hearts, or who are seriously ill, circulatory failure may result. Or if a fatal termination has been avoided the call upon the patient's slender resources will gravely handicap him in his recovery. Anæsthesia must, therefore, be kept light in these subjects and still further diminished in depth if even slight signs of exhaustion show themselves.

The question arises whether you are justified in selecting C.E. as a routine anæsthetic if, from want of practice, you find that ether presents too many difficulties. As I have already pointed out, it is not safe as ether, although it is safer than chloroform. It is comparatively easy to administer and is an excellent anæsthetic for the great majority of cases, although it does not protect against shock so well as ether; the blood pressure is less well-maintained owing to the high proportion of chloroform in the mixture (C_2E_3). Moreover, it introduces the danger of delayed chloroform poisoning. Both these disadvantages can be remedied almost entirely, if not completely, the latter by the administration of glucose beforehand—a practice which is in force here, the former by the frequent douching of the mask with ether. If you adopt this method, you will find that with a little practice, and faith, you can, more and more, maintain an anæsthesia which is, to all intents and purposes, an ether anæsthesia. Dr. Silk has introduced a mixture of C_1E_{32} which he calls "modified open ether." He uses it from the start and speaks well of it. Or you may use C_1E_4, or try the Bristol "two-bottle" method, in which chloroform and ether are dropped alternately on to the mask, the ether always predominating and the aim being a modified ether anæsthesia. In all these mixtures and methods the anæsthetist keeps in front of him the dangers of pure choloroform anæsthesia. And if you use C.E. alone you must remember to avoid the mistake of adding it irregularly to the mask.

For short operations, if the patient is suitable, complete relaxation is not needed, and slight movements are not inconvenient, you should choose nitrous oxide and oxygen. I refer to such operations as the removal of small tumours, scraping sinuses, painful dressings, etc. For operations in which deep anæsthesia of two or three minutes' duration is required, ethyl chloride on the open mask can be chosen, or the nitrous-oxide-ethyl chloride sequence. This is a method which I was fond of using in the Dental Department for the alcoholic and the very robust. Dislocations are best reduced under ether.

Spinal anæsthesia has a definite field of usefulness, and you will do well to learn all you can about this method. The principles underlying its administration are pretty well known and the technique not difficult; the results are constant and well under control if the stovaine glucose solution is used. It offers many advantages and in skilled hands fatalities are almost unknown, whilst it is true to say that it has been the means of saving many lives.

Relaxation is perfect, so perfect that in a prolonged operation, such as the abdomino-perineal excision of a carcinoma of the rectum, not only is the patient spared much forcible retraction, but as much as 10 to 15 minutes are saved on the first stage. Shock is prevented or much diminished by the blocking of centripetal sensory impulses. Post-operative complications, bronchial, pulmonary, and renal, are rare. For these reasons spinal anæsthesia is invaluable for many cases of intestinal obstruction, for strangulated hernia in elderly subjects, for cystoscopy of tuberculous bladders, for resection of bladder growths, and for prostatectomy. Patients with enlarged prostates are frequently broken down, suffering from diseased kidneys, bronchitis, and worn out from loss of sleep. General anæsthesia is attended with a high rate of mortality. Carter Braine published some years ago a most instructive paper on the results of anæsthetics in 200 consecutive cases of prostatectomy. Rigidity, circulatory failure, arrest of breathing were noted in a large proportion of the cases, and no one anæsthetic was found to be really satisfactory, perhaps the best results being obtained with a mixture of $C_{11}E_1$. Spinal anæsthesia was practically unknown at that time, but it is used now at St. Peter's Hospital extensively, and there is no doubt in the mind of my colleagues, nor in mine, that it is by far the best anæsthetic for all bladder cases in elderly subjects, and for certain special cases in younger subjects. The recovery is unattended by vomiting or nausea, and the method has become so popular for this reason that patients frequently ask for it. Headache is sometimes an unpleasant complication, lasting perhaps for several days. Spinal anæsthesia offers another advantage. In acute intestinal obstruction due to general peritonitis the bowels are frequently opened on the table. This is due to the abolition of the inhibitory reflex through the splanchnic nerves. Further, the distended bowels do not tend to escape from the abdomen. It is also valuable in diabetic gangrene and in acute respiratory disease. It must, however, be used with caution in patients who are already suffering from shock; the fall of blood pressure which follows about 15 minutes after injection may cause alarming symptoms or even death. It must certainly never be used in patients suffering from profound shock and loss of blood, and never in aortic regurgitation. The dosage is of great importance and must be graded to suit each individual case. Experience is necessary in this as in other methods. Fortunately we know now that the drug is quickly fixed, and that the Trendelenburg posture can be safely used within 10 minutes from the time of injection of the heavy solution. Gravity alone will therefore often restore a low blood pressure, or the abdomen may be gently squeezed and the legs raised. If the retention of consciousness is embarrassing to the patient, nitrous-oxide and oxygen should be given, or a little C.E. In many cases of intestinal obstruction with vomiting consciousness must not be abolished.

In selecting your anæsthetic the convenience of the operator has to be taken into account. Your choice must sometimes be a compromise. It is obvious that of two anæsthetics which are equally safe it is better practice to choose that which enables the surgeon to do his operation efficiently rather than the one which may hamper him in his work. Consider the case of ether compared with nitrous-oxide-oxygen-ether in abdominal surgery. Some surgeons find that they can do satisfactory work with the latter in the great majority of their abdominal cases. They have learnt to adapt themselves to the special difficulties and shortcomings of this anæsthetic, and they consider that their results prove that the patients have benefited. Others prefer ether for abdominal surgery, and will only tolerate nitrous-oxide-oxygen-ether for special cases. It is not wise, therefore, for you to try to force this anæsthetic upon a surgeon who is not well disposed towards it, however convinced you may be theoretically that it is better for his patients. If you can persuade him to make a fresh trial of it and to combine it with local infiltration of novocaine, you are adopting a scientific attitude, for you have in your support not only the work of Crile but the experience gained in the C.C.S. in France, and the results of your persistence will quickly be apparent in the improved post-operative condition of the patients. In this connection I would urge you to make a pilgrimage to a hospital where nitrous-oxide-oxygen-ether is constantly being employed for abdominal surgery and see for yourself its advantages and disadvantages. You will be welcome.

There are certain factors connected with the patient which modify or dictate the choice of anæsthetic. Try to take a general survey of

him. This implies a consideration not only of his age, general physique and fitness, but of his temperament and habits. This is important not only in helping to decide upon the anæsthetic but in giving an indication of any difficulties that may arise and of the way in which the patient with "take the anæsthetic." It is well to remember that the healthy vigorous athlete is not the best subject to anæsthetise. It is true that he will stand strain better than the patient who is comparatively feeble and has led a sedentary blameless life, but he will offer more difficulties during induction and be more difficult to relax. The stage of excitement is apt to be prolonged, and is marked by struggling and spasm of the muscles of the jaw and neck. Both of these complications interfere with respiration and lead to congestion, cyanosis and cardiac strain. When such a condition arises do not desert ether and fly to C.E. or chloroform —I have already given you reasons against this course—but open the mouth to restore the airway and you will find that the difficulties will quickly disappear. If you have not examined carefully the shape of the mouth and the arrangement of the teeth beforehand you will certainly regret it now and may in your hurry do some damage. If the patient is edentulous you can relieve the spasm of the lips and jaws by inserting a finger in the angle of the lips and keeping an airway open. Be careful when anæsthetising a patient who is suffering from trismus or rigidity of the jaw. Open methods, plenty of oxygen and watchfulness are essential. I was recently asked to anæsthetise a girl who was suffering from quinsy and trismus, a dangerous combination, but by careful attention to induction and the early use of ether a light anæsthesia, which allowed the mouth to be opened, was obtained without difficulty. The table was then tilted slightly towards the head and the head turned to the side. On incision pus escaped freely and ran out of the cheek. Avoid nitrous-oxide in these cases, for the deep breathing induced by this anæsthetic, however skilfully given, may lead to aspiration of pus and possibly immediate death from asphyxia. Such cases are not unknown. Obesity, which is frequently combined with anæmia, demands an ample supply of air; therefore use closed methods sparingly. C.E. and oxygen are probably better than ether if the operation is to be at all prolonged. Nitrous-oxide and oxygen is not an easy anæsthetic in these patients, and if given for any special reason you must be on your guard against introducing the smallest element of anoxæmia.

Age is, in itself, of less importance than the conditions which are associated with it at different periods of life. Babies and very young children do not tolerate either operation or anæsthesia well; they stand loss of blood very badly. Ether must be used sparingly, and it is wiser to give them C.E. and oxygen and to keep anæsthesia as light as is consistent with the proper performance of the operation. I think this is the best method for such an operation as that for cleft palate; many of these infants are poorly nourished and quickly show signs of severe shock if deep ether anæsthesia is maintained. The same remarks apply to old people; they are soon exhausted by the strong stimulation of ether, and any asphyxial element is very harmful to their impaired cardio-vascular and nervous systems. Fat "stuffy" children need careful handling. If sepsis is present in young children you must use ether, unless glucose has been administered beforehand. Older children may be treated on general lines—nitrous-oxide and oxygen is suitable in experienced hands.

Temperament. Highly-strung, neurotic and hysterical people are difficult. Complete relaxation is not easily obtained, and they are very liable to reflex disturbances of respiration, particularly if sensitive structures such as parietal peritoneum or the rectal sphincters are being handled. Deep anæsthesia is necessary, and you will do well to use ether somewhat freely and especially before the operation is begun. Induction with chloroform is more than usually dangerous in very frightened patients. If preliminary narcotics are given, the dose should be proportionately larger than in the normal subject. It is here that morphine-scopolamine is so useful.

Habits. Alcoholics are troublesome subjects to anæsthetise, for, as you know, they struggle violently during induction and need large quantities of the anæsthetic to procure relaxation. On the other hand, their cardio-vascular system is unable to withstand strain, that is, their resistance is lowered. Although they consider themselves healthy and frequently present a robust appearance, you will find that they quickly show signs of exhaustion under

deep anæsthesia, and unless you have been watchful and have taken every opportunity to cut down the amount of anæsthetic you may have some difficulty in carrying them successfully through a major operation. The subjects of carcinoma of the mouth are frequently alcoholic and very often elderly, and the operation may be one of some magnitude and accompanied with considerable bleeding. If you are giving intra-tracheal ether you have the opportunity, and should take it, of keeping anæsthesia light, and should, indeed, towards the end work with a level of anæsthesia which permits of occasional movements. These can be controlled, but the remedy for shock in elderly subjects is not so obvious. The conduct of anæsthesia for an abdominal operation is sometimes a matter of great difficulty and anxiety in these subjects. Here it may be necessary to push the anæsthetic in order to obtain complete relaxation, and if the patient is suffering from some acute condition such as a perforated duodenal ulcer and the recti are rigid, your task will not be an enviable one. Sweating, pallor, poor pulse frequently co-exist with deep anæsthesia and imperfect relaxation. If you cannot obtain the desired result with ether, you will be tempted to use C.E. or to add some of this mixture to the mask. The latter is the better practice, but the quantity added must be small and the effect carefully noted. Do not allow yourself to be hurried; the border line is easily overstepped. It is in such cases that the combination of spinal and general anæsthesia may be of great service. In the alcoholic class must be placed certain sections of the community, of both sexes, who live well. They take alcohol regularly, and not infrequently between meals, and although they are not alcoholics in the accepted sense their behaviour under anæsthetics is not dissimilar. Nitrous-oxide and oxygen alone is of small use, better results being obtained by preliminary alkaloids and the addition of ether. As a rule chloroform is taken badly; if it is used give oxygen at the same time.

Excessive tobacco smoking often leads to chronic pharyngitis; jaw spasm and persistent coughing are to be expected. Some of these subjects are difficult to handle, and display alarming symptoms if chloroform or one of its mixtures has to be pushed. Undoubtedly in these cases the heart has been chiefly affected. I remember the case of an elderly retired doctor who had to have an anæsthetic for the examination of his abdomen. He was a short, thick-set, muscular man, with large abdomen and rigid chest. He led an active outdoor life, being very fond of gardening, but had been in the habit for many years of smoking 15 pipes a day of strong tobacco. He was excessively nervous about the anæsthetic, but took C.E. quite well at first. It was essential to obtain deep anæsthesia and quiet respiration in order to make a careful and thorough palpation, and as the abdominal walls were thick and the muscle somewhat rigid, the anæsthetic had to be pushed. It was soon noticeable that his colour became poor and that he began to sweat, and it was obvious that deep anæsthesia would be attended with some risk. Such was the case, his condition rapidly became alarming, and at a stage when the recti were still rigid, his pulse at the face suddenly became impalpable, although respiration was present, but weak. After considerable trouble he was resuscitated, and the examination was then easily completed without any further anæsthetic. In such a case the satisfactory performance of laparotomy is almost impossible with the usual methods of anæsthesia, and recourse must be had to spinal anæsthesia and C.E.

Respiratory and *circulatory disease* modify the selection of the anæsthetic, but knowledge of the action of the different anæsthetics and a comprehension of general principles should enable you to select the appropriate drug and to avoid obvious errors of judgment. Careful inspection of the way in which the patient lies, walks and breathes, and the eliciting of information as to his physical energy and capacity to play games or to go upstairs are probably of more value than the most exact percussion and auscultation of the chest. Patients with considerable dyspnœa are usually over-anxious at the prospect of taking an anæsthetic and need sympathy and re-assurance. They have to be anæsthetised in the sitting or semi-recumbent position, and plenty of time and trouble must be devoted to their comfort. Oxygen must be given freely and closed methods avoided as they resent the least limitation of air-supply and the presence of closely-fitting face-pieces. They should be lowered into the horizontal position when unconscious. In the case of empyema the patient should on no account be operated upon lying on the sound side. This side should be uppermost, as it is

the only lung left to the patient and the risk of infection of the unaffected side must be avoided. The prone, or three-quarter prone, posture must be adopted, with the shoulder held up in order to allow of the free expansion of the healthy lung. Anæsthesia must on no account be deep; fortunately these patients are less liable than usual to display inconvenient reflex phenomena under light anæsthesia. Chronic bronchitics are difficult subjects for upper abdominal operations, and complete relaxation may be impossible to procure. Patients with a very slow pulse do not take chloroform well, extreme pallor, sweating, and Cheyne-Stokes breathing being met with, due to cerebral anæmia. Valvular affections are of little consequence if the patient is able to lead a normally active life. If the pulse is rapid, irregular or intermittent, the position is altered, and C.E. and oxygen is to be preferred to ether. Temporary improvement of the circulation is liable to be followed by a reaction when the anæsthetic is withdrawn, or by a serious deterioration in the quality of the pulse during the actual operation if this be prolonged. I had on one occasion to anæsthetise a doctor for acute appendicitis who was suffering from tachycardia. His pulse rate was about 300 and it remained uncountable during the operation; towards the end his condition gave me much anxiety, and that evening vigorous measures had to be taken to combat cardiac failure. I had used C.E. and oxygen; probably spinal anæsthesia would have been better. Three months later, when a ventral hernia had to be repaired, his cardiac condition was normal and he took ether perfectly well.

Atheroma, aneurysm, high blood-pressure are chiefly dangerous during induction. Cerebral hæmorrhage has been reported on several occasions; the cause has usually been violent struggling or the unwise use of ether. I have reported a case of successful laparotomy on a man suffering from a large thoracic aneurysm who had been advised not to have an anæsthetic. Morphine and oil-ether were used for induction; C.E. and oxygen for the operation. Some years ago I had to anæsthetise an old man for amputation of the penis, who had already had a cerebral hæmorrhage. I was not proficient in the use of spinal anæsthesia and gave him chloroform, and in spite of severe struggling fortunately all went well. The risk of chloroform must sometimes be run in these abnormal cases. This morning I had to anæsthetise a middle-aged woman for amputation of the breast. She had a blood pressure of 220 mm. Hg. or more; it had certainly been higher, and when I took it two days before operation it was well over 220, but could not be measured accurately because of the discomfort caused. She had taken nitrous oxide a short time previously for the extraction of teeth and had experienced severe cardiac pain and pain radiating down the left arm both during induction and during recovery. Obviously the absence of oxygen had raised the venous pressure. She was, not unnaturally, nervous, and I decided to give her 1/6th gr. morphine and 1/150th gr. scopolamine an hour before operation, and to use chloroform and oxygen throughout. She was distinctly sleepy as the result of the injection and showed very little excitement during induction. There was no difficulty with the anæsthetic.* You will notice that in such a case as this, where the cerebral blood supply is unusually good, there is no objection to preceding the administration of chloroform by morphine.

What about the opposite condition; the condition, I mean, of low blood-pressure? This has been partly discussed in my remarks about spinal anæsthesia. Nitrous oxide and oxygen is the best anæsthetic for many of these cases, especially when the condition is due to shock or loss of blood. In some of them you may find it difficult to obtain quietude in the absence of morphine, which you will have withheld. Do not be tempted to deepen anæsthesia by cutting down the oxygen. You may do much harm which may or may not show itself on the table, but will certainly not fail to do so afterwards. Use, instead, a very little ether with the nitrous oxide and give plenty of oxygen. Nothing is so deleterious to these patients as shortage of oxygen. Failing nitrous oxide and oxygen, give warm ether and oxygen and keep the anæsthesia light. Chloroform is contra-indicated.

The "acute abdomen" concerns you closely. The selection of the anæsthetic is dominated largely by two factors, shock and vomiting. My remarks on spinal anæsthesia will have led you to understand that this anæsthetic is the best in the great majority of

*A good recovery was made except for a sharp attack of cardiac pain that evening, the cause of which was unknown.

these cases. You will also have realised that it must be used with caution and the dose carefully regulated in conditions which have as their chief characteristic a low blood-pressure. On the other hand, the presence of frequent vomiting renders the administration of a general anæsthetic in the highest degree dangerous. Nor is it only vomiting which has to be considered, for this is an act which is not performed without well-recognised premonitory signs. Regurgitation of large quantities of fluid, arising merely as the result of relaxation or unconsciousness, or produced by manipulations of the distended intestines may occur quietly and without warning, and the respiratory passages may be invaded before preventive measures can be taken. Further, the loss of body fluids caused by repeated vomiting reduces the blood-pressure. The anæsthetist is, therefore, faced with a position which demands the most careful and deliberate judgment if the patient is to receive the best possible chance.

There now enters a third factor which will incline him to select spinal anæsthesia. I mean the factor of rigidity, for he is aware that deep anæsthesia under these conditions is both harmful and dangerous, not only by reason of increase of the shock already present, but because of the danger of inhalation of vomit. In some of these cases the assumption of the proper posture may be very inconvenient to the patient, but a light degree of anæsthesia with C.E. and E., close watch being kept on the patency of the air-passages, may be procured for the actual puncture. If for some reason general anæsthesia has been chosen for the operation, it is obviously necessary to avoid closed methods, such as nitrous-oxide and oxygen, although this anæsthetic might be entirely suitable and indeed indicated for a case, for example, of localised peritonitis which was not complicated by vomiting. Other precautions to take, beside that of choosing open methods, are to keep one shoulder of the patient elevated by a pillow, to turn the head to the opposite side and to insert a gag or prop in the mouth. Sponges must be kept at hand. Fatalities have frequently been recorded in connection with this type of case, death ensuing from heart failure arising from impeded respiration or from the inhalation of vomit, or from shock. Oxygen should be used freely and a fair proportion of ether, preferably warm, added to the chloroform if a mixture is being given.

Tonsil and adenoid operations may be divided into two classes (1) the short guillotine operation and (2) the deliberate enucleation. In the former class anæsthesia is easily and quickly induced with open ethyl chloride, followed by a few drops of C.E., and continued with ether until the globes are fixed, the corneal reflex still being brisk. For the latter class it is better to continue the administration of ether until the pharyngeal reflexes are abolished, to place the head in the dependent position so that the blood collects in the naso-pharynx and to pump in chloroform (better still, a mixture of chloroform and ether vapours, the latter predominating) when the reflexes begin to return. It is essential that the breathing be kept perfectly free, the colour good. If cyanosis appears and cannot be immediately remedied, oxygen should be freely used. The lateral posture is preferred by some surgeons; it has undoubted merits.

In nasal operations the risk of entry of blood and pus into the trachea is best avoided, unless the anæsthetist is expert, by maintaining a light anæsthesia in which the cough reflex is not abolished. Here I must utter a word of warning. Cocaine is frequently painted on the mucous membrane before anæsthesia, and in some cases a few drops trickle down into the pharynx and reduce the sensibility of the reflexes. As in the tonsil operation, so in nasal operations some surgeons prefer the lateral posture; if this be adopted anæsthesia can be maintained at a deeper level, and inconvenient interruptions due to coughing and swallowing are avoided.

A few words may be said on the subject of the preliminary injection of narcotics. It has become almost a practice in hospital to order the same dose for all patients, viz., 1/6th gr. of morphine. This is obviously opposed to the right principle of suiting the dose to the patient. It is, however, common knowledge that it is a practice which has worked well in the past, in the very great majority of instances, and it appears to me that careful judgment has been exercised in the selection of cases in order to obtain this result. If criticism can be made, it would be that in some instances there has been a tendency to err in the direction of under-dosage. This is a fault on the right side, more particularly as the anæsthetic has not infrequently to be administered by a comparatively inexperienced anæsthetist. It is, I think, fairly easy to lay down the contra-

indications to the use of narcotics. There is general agreement among experienced anæsthetists that morphine should not be given before chloroform, except for special reasons, as both of these drugs depress the respiratory centre and not only is anæsthesia obtained with difficulty, and in especial profound anæsthesia, but there is little tendency for the centre to recover from a depth of narcosis which would under ordinary conditions be well within the margin of safety. Nor should it, in my opinion, be given to children or old people, rarely to adolescents, nor to patients who are cyanosed or drowsy, or whose vitality is depressed by such causes as shock, hæmorrhage, toxæmia or starvation. Cerebral operations were formerly considered specially suitable for morphine, but experience has proved the error of this view. Nor is morphine without disadvantage in mouth, nose and throat operations, in which it is important that the protective reflexes of the larynx and trachea should be active both in the operative and the recovery periods. An additional reason is that in many of these cases chloroform in used.

Papers by Guy's Men.

Arthur F. Hurst, M.A., M.D., B.Ch., F.R.C.P., The Croonian Lectures on the Psychology of the Special Senses and their Functional Disorders, Lec. II., Pathogenesis of Hysterical Cutaneous Anæsthesia (Illust.).—*Lancet*, July 31st, 1920, p.235.

H. W. Barber, M.D., Case of Lupus Erythematous treated with Autogenous Streptococcal Vaccine prepared from Enucleated Tonsils.—Proc. Roy. Soc. Med., Sec. of Dermat., June, 1920, p.94.

W. M. Mollison, M.Ch. (1) Case of Lupus of the Palate, p.149; (2) Case of Streptococcal Ulcer on the Arytaenoid, p.150; (3) Case of ?Neoplasm of Larynx, p.150.—*Ibid.*, Sec. of Laryngology.

T. G. Stevens, M.D., Specimen of Douche Nozzle removed from the Female Bladder.—*Ibid.*, Sec. of Obstetrics and Gynæcology, p.129.

T. G. Stevens, M.D., Case of Sacculation of a Gravid Bicornute Uterus.—*Ibid.*, p.154.

S. H. Browning, M.R.C.S., L.R.C.P., The Radical Cure of Gonorrhœal Iritis.—*Ibid.*, Sec. of Ophthalmology, p.44.

T. B. Layton, M.S., Case in which a Blow on the Mastoid Process caused Partial Destruction of the Auditory Nerve with Destruction of the Vestibular Nerve.—*Ibid.*, Sec. of Otology, p.102.

Arthur F. Hurst, M.A., M.D., B.Ch., F.R.C.P., The Croonian Lectures on the Psychology of the Special Senses and their Functional Disorders, Lec. IV., Seeing, Looking, and Hysterical Blindness.—*Lancet*, August 14th, 1920, p.333.

Obituary.

Oswald Thomas McLaren.

We regret to have to record the death from drowning of Oswald Thomas MacLaren, which took place at Sidestrand, Norfolk, on Saturday, August 14th. He was bathing with his brother and sister at the time. His brother, who had only one arm, first got into difficulties, and despite the heroic efforts of a boy scout, aged 15, who swam about until all hope of a rescue had vanished, both the brothers were lost.

Oswald MacLaren entered Guy's in October, 1916. He passed his second conjoint Exam in April, 1918, and subsequently served as a Sub.-Lieut. in the Royal Naval Volunteer Reserve. He passed in Midwifery at the final Conjoint Exam in July of the present year.

During his four years at Guy's he had made many friends. To these, and to his relatives, we offer our sincerest sympathy at a tragedy which has cut short a career of unusual promise.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Rowing at Guy's.

DEAR SIR,—The official Henley Records contain an interesting comment on the race for the Stewards' Challenge Cup in which the Guy's Boat Club took part in 1846. The first heat was against the Dreadnought Club of Henley (a Club which is, I imagine, long since extinct). The result was judged a dead heat, but the Dreadnought Club were so confident that they had really won that they refused to row the heat again. Under these circumstances it was decided that Guy's should contest the final with the only other entrants, an O.U.B.C. four. The O.U.B.C. four won the final, as Mr. Tom Bird mentions in the postscript to his letter in the last number of the GAZETTE.

Of course, rowing in those days was a very different thing to the modern sport, but it is to be hoped that the year 1846 will not be allowed to hold the distinction of being the only year in which a Guy's crew competed at Henley Regatta.—Yours faithfully,

LEANDER.

August 30th, 1920.

DEAR SIR,—I was interested to read Sir G. Savage's letter re the old Guy's Boat Club. I fancy that ceased to exist soon after 1872. I remember

going down to Putney to see our crew train for the race against Bart.'s, I think in '72. Bart.'s, as far as memory carries me, was stroked by S. D. Darbishire, the well-known Oxford stroke. In our boat was Day, E. O., Cotton, H., Amphlete, and I believe W. E. Paby was cox. I know we won, much to Darbishire's disgust. I think the reason the Club went under was on account of the distance and trouble getting down, though in '72 there must have been a goodly number belonging to the Club, as in the Ilex Swimming Club, all the members of which had to belong to a Boat Club. There was a large number of members from Guy's. Am I right in saying the original Diamond Sculls (Guy's) were held by Cooper Forster and Wilks? Perhaps Sir George Savage may know.—Yours truly,

WM. E. DRING.

Tenterden,
18th August, 1920.

Inter-Hospital Billiard Cup.

DEAR SIR,—Perhaps I am treading on dangerous ground, but surely there could be found room in the already overburdened glass cases (GAZETTE, August 7th) for the handsome Inter-Hospital Billiard Cup which was won in 1913, before a distinguished crowd headed by the "Baron," etc. This Cup was given to Burrough Watts & Co. to have the name of the Hospital placed on it, and since, from information received, is now somewhere in their warehouse, lost and forgotten. I well know that billiards is not encouraged by the authorities, still the Cup belongs to Guy's, and should rest with the others. —Yours faithfully,

H. C. BATCHELOR.

22, Algiers Road,
Ladywell, S.E.
August 24th, 1920.

Guy's Hospital Antiquities.

DEAR SIR,—I have recently received some very interesting and unique presentations to the Museum of Antiquities. A Certificate issued in 1835, and signed by James Stocker (the Apothecary in those days), and also a number of receipts signed by eminent old Guy's men. These receipts are acknowledgements for a quarter's salary received, and include such men as C. Aston Key, Bransley B. Cooper, Thomas Addison, B. G. Babington, Edward Cock, John Morgan, F. Callaway, Richard Bright and numerous others.

These very valuable additions have been sent to the Librarian for the Museum of Antiquities, and may be viewed at any time. It is interesting to note that although the salary paid to these gentlemen did not exceed more than £10 per quarter, a sixpenny receipt stamp was required for each.

The Certificate, which has been presented by Mr. W. M. Mollison, contains on the one side a view of the Hospital about the year 1830, and on the other details of the Certificate, entitling a pupil to 12 months' Hospital practice at the joint Hospitals of Guy's and St. Thomas's, and signed on October 10th, 1835.

N.B.—At this period St. Thomas's Hospital was situated immediately opposite Guy's in St. Thomas's Street.—Yours faithfully,

J. H. E. WINSTON.

Medical School, Guy's Hospital,
London Bridge, S.E.1.
August 30th, 1920.

Dr. Wood's Article.

DEAR MR. EDITOR,—I think you might like to correct an unfortunate printer's error at the end (last paragraph) of Dr. Wood's delightful account of his experiences at Guy's. He was a year with us and not a *month*: what he has to say is consequently of infinitely greater value than what it would be if he really had only had a month at Guy's.—Yours faithfully,

ARTHUR F. HURST.

17, Devonshire Street,
Portland Place, W.
August 21st, 1920.

Guyoscopy.

MOST CULTURED SIR,—You have indeed honoured me by your request to send you for publication in your influential GAZETTE a report of my feeble address given before the Society for the Propagation of Guyoscopy in the distressed districts of China. Confident of its possibilities and convinced of the fundamental character of the truths upon which this glorious science has been erected, and having ever before my eyes the great ideal of the ultimate Guyoscopisation of the Continent of Asia, I have, if I may say so without immodesty, spared no pains to utilise the arts of resourcefulness or the resources of artfulness, both in reason and in rhetoric, to bring home to China your persuasive arguments.

The Bishop of Hong Kong took the chair, and offered a prayer that the faith of my audience might not be shaken by anything reasonable that I might chance to say, and thereupon I delivered myself as follows:—

My Lord, Gentlemen, and Medical Students.—It is my proud privilege to approach you upon the burning topic of Guyoscopy. Guyoscopy, as its name implies, is a copy of the principles of Guyos, the celebrated physiologist and somnambulist of the pre-Socratic epoch. Guyos was, except for the circumstance of time, a contemporary of Buddha. He

was a remarkable astrologist, but, greatest of all, a philosopher and physician. Indeed, he was the first to administer medicines in aqueous solution, being convinced that our bodies would not add on drugs, otherwise, *corpora non adduntur nisi soluta*. Early in his youth he had shaken himself free from the prevalent notions of his people, declaring that all dogmas in -ist, -ic, or -ism were mere superstitions. His clear practical outlook is exemplified in a story told of him that, at his baptism, on emerging from the water, he remarked that he hoped in future they would use a thermostat to keep the tank decently at thirty-seven degrees Centigrade, for his intra-uterine experience had accustomed him to this temperature, and he saw no reason for the change. Of course, all this can be hinted in one word in Chinese.

But all the experiences of his strange youth and the acquisitions of his remarkable adolescence were but preparatory to the realisation of his profound purpose in the promulgation of the principle of Guyoscopy. What then is Guyoscopy? This is the question I have come before you to answer. Guyoscopy is a science; yet it is more than a science. Guyoscopy is an art, yet it is greater than an art. It is, in a word, or rather two words, an artful science. It consists in doing as they do at Guy's, the home of Guyos.

But if you ask me, as a question, what they do at Guy's, I must answer you after the manner of a great Chinese obstetrician, who was asked "How can a doctor be certain of pregnancy?" and his reply was "Wait and see."

For consider the case of a visible, palpable, ponderable tumour, in the region of the right hypogastrium, or elsewhere, and let the diagnosis of the physician be X and of the registrar be Y, or if there be two registrars Y^1 and Y^2, for why not, and let there be in addition as many medical ward clerks as you will, each with his separate diagnosis, either positive or negative, forming the well-known mathematical series $(a^1+a^2+a^3+ \ldots \ldots -b^1-b^2-b^3- \ldots \ldots)$ where A may be the same as B or different, and now let the surgeon be called, and let his diagnosis be neither Y nor X, but Z. How then can these results be harmonised into one complete mathematical expression in which Z=Y=X? This can be done by Guyoscopy. For clearly on mathematical grounds we may neglect insignificant terms such as are represented by the unqualified ward clerks, their contribution being in algebraical parlance, infinitely small. On the other hand, the terms Z, Y and X will all become equally large at infinity, that is to say, the diagnoses will all become equally correct if we wait sufficiently long, since parallel lines meet at infinity. We have then simply to write Y=f(X) and Z=f(Y) and all difficulty vanishes. This being so, it is clear that a perfect diagnosis, that is to say, one satisfying the demands of X, Y or Z, must be represented by a parabola, placed obliquely to the axes of these three possibilities, and have its extremities ending in vacuo. In short, the parabola must be Guyoscopic.—Your humble servant,

HO HO.

August 24th, 1920.

Health Administration in London and Residential Institutions.

The Metropolitan Asylums Board at their last meeting adopted a report by their General Purposes Committee on the recent proposals of the London County Council for the division of all health services in London between the County Council and the Metropolitan Borough Councils. These proposals include the taking over by the County Council of about 150 large hospitals and other institutions (with 80,000 patients and a large staff) which are at present managed by the Asylums Board and the Metropolitan Boards of Guardians. The County Council's suggestions are based on the terms of the Maclean report on Reconstruction. It should be noted, however, that this report which was produced not as the result of an enquiry on present conditions but on the basis of the Poor Law Commission's Report of 1909, has not met with universal acceptance. The County Councils Association, the Association of Municipal Corporations and the Poor Law Guardians of the country do not agree with its conclusions; and the Minister of Health, Dr. Addison, has stated that the administrative difficulties which have to be disentangled and overcome in the matters dealt with go far beyond the general recommendations made by the Committee, who were confronted with the biggest problem of local government that stands before this country.

The Board call attention to the fact that the Council have many times during the last few years expressed themselves as dissatisfied with the present condition of local government in the metropolis. The Council have come to the conclusion that the constitution of the Metropolitan Water Board should be altered.

They also think that the markets should be under their control. Again they have asked for a Government Enquiry into the question of extending the existing county boundaries into a "Greater London" with a unified administration for health and other important services, and they have also mentioned as a possible basis for a future province of London the addition of the five home counties with an area of 4,758 square miles, a population of

over nine millions, and a rateable value of £72,000,000. The Speaker's Conference on Devolution has proposed local parliaments for England, Scotland and Wales.

Two recent Committees of the Ministry of Health, Lord Dawson's on medical services and the Committee on Unhealthy Areas, also advise that these important problems of local government should receive attention. On these grounds, therefore, amongst others, the Asylums Board suggest that the present moment when the whole question is in the melting pot is singularly inopportune for dealing piecemeal with the matter. That this view is, or was recently, shared by the Council is shown by a report in which the Council state that they cannot contemplate without dismay the prospect of solving these urgent problems of London piecemeal and independently as *in the past, and that they must be dealt with as* a single considered plan.

The Asylums Board think that an authoritative Enquiry as proposed by the County Council should be undertaken by the Government into the question of London government as a comprehensive whole, including the proposed extension of boundaries, the constitution of a central council with local legislative powers, the relations between the legislative council and the administrative departments dealing with the main public services, and other cognate questions. Pending the result of this full investigation the Board think that it is inadvisable to proceed to make further important changes in individual branches of the public services of London. They believe that such an authoritative Enquiry would afford an opportunity for a statesmanlike scheme for a legislative Council for Greater London with its administrative adjuncts dealing with health, education, etc.—a scheme drawn up with a breadth of vision worthy of the greatest city in the world.

There are further practical difficulties in the way of the Council's proposals. It is not easy to see how the Council can possibly undertake successfully the extra duties which would be imposed upon them by the control of the 50 institutions (with 25,000 inmates) at present belonging to the Metropolitan Asylums Board. The Council find it necessary now in order that the work may be efficiently carried out to add co-opted members to such of their committees as control institutions. The fact that the attendances of these co-opted members compare very favourably with those of the elected members of the Council shows that the latter are fully occupied with the work of the Council proper.

The Asylums Board is by far the largest institution authority in this country. It has a unique record in opening and administering hospitals, asylums, schools and homes. When at the beginning of the war refugees from the continent came pouring into this country in thousands and it was necessary to make arrangements without a moment's delay to house and feed and clothe them, the Government in their need turned to the Asylums Board, knowing that with its 60 years' varied experience, its trained expert officials, and its great resources, it would be able to meet all demands made upon it; and they did not turn in vain. Many members of the Board devote the whole of their time to the Board's work; and the experience of the Board is that it is by the personal interest of a sufficiently numerous body of representatives, giving a large proportion of their time to these special duties, that the welfare of the patients is secured, and that efficient and economical management of the institutions is maintained. The inclusion of this great work with that of the general municipal duties of the London County Council may well be viewed with uncertainty and hesitation.

The constitution of the Board is a matter for discussion. Without questioning the validity of the principle of direct election in parliamentary and municipal bodies, it may well be urged that there are many specialised subjects which can safely be left to the jurisdiction of representatives from other directly elected bodies chosen for their fitness for the work and for the time they have to give to it rather than by a popular election conducted, as it must necessarily be, on a political basis. It has not been the least merit of the Metropolitan Asylums Board that party politics have played no part in its proceedings, nor can it be understood why such considerations should enter into the constitution of a body whose concern is the care of the sick. The Board recognise, however, that their constitution needs amendment, and they propose that each Metropolitan Borough Council should be given representation on the Metropolitan Asylums Board, since so much of the Board's work in relation to infectious disease and tuberculosis is not poor law work, and brings the Board into relationship with the Councils. At the same time representation could be given to the London County Council by their nominating some of their number to serve on the Board, a course for which there are many precedents. The Board also recommend that their name should be altered to one more in keeping with the nature of their work. Such immediate changes could be readily made and would in no way prejudice the future developments in London government as a whole.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Reviews.

Woodwark's *Manual of Medicine* (2nd edition). (Messrs. Henry Frowde and Hodder & Stoughton) price 16s. net.

This book, the first edition of which appeared in pre-war days, undertakes to provide not only a handbook for the student clerking in a teaching hospital, but also a work of reference for the busy practitioner, and these within the space of 400 odd pages.

From the student's point of view, we consider that the lists of conditions which may give rise to some particular symptoms are, in the absence of some marked differentiation of their relative frequency, calculated to perpetuate that tendency, encouraged by the stress laid on ward rather than out-patient teaching, on the part of the raw medico to overlook the obvious in the search for the rarity.

For the student, and the practitioner no less, it is of more importance to differentiate the abdominal conditions which require laparotomy from those which do not than to attempt to diagnose before operation the precise variety of "acute abdomen." Hence we consider that constipation, together with a loaded cæcum, deserves some place in the table of conditions mistaken for appendicitis. Incidentally a variation in the size of type used has been attempted in the table of contents, where we find syphilis relegated to small type, in spite of Osler's dictum, "Know Syphilis, and all things clinical shall be added unto you." The limitations of space necessitate a dogmatic attitude—here and there, however, this has its own dangers, as in such a half truth as "the stomach should be empty eight hours after a meal." Under Grave's disease, the space employed by a catalogue of the various disturbances of mechanisms associated with the eye might well have been employed with a mention of the "nervous shock" so often associated with the onset of the disease. The present volume maintains the tradition of the Oxford Medical Publications; paper and print are good, and the few errors of typescript such as "pyrammidal" in Plate I. and "nob" on page 79 are almost worth retaining as light relief. It is not the fault of the author that Medicine cannot be forced into the Procrustean bed he has tried to make it fit; rather is it marvellous to find in such a handy volume so great a mass of information.

The Duties of Sisters in Small Hospitals. By Félice Norton (Messrs. Ballière Tindall & Cox) price 4s. 6d.

This little book claims to be written for "the newly certificated nurse embarking upon her first Sister's post" in a hospital of under 100 beds. The subject is divided into chapters on the work of a Ward Sister, Theatre Sister, Casualty, Night and Home Sister, each of whom will find valuable information and advice about her especial duties and difficulties.

The seventh edition of Hutchison and Rainy's *Clinical Methods* and the fifth edition of Mr. Comyns Berkeley's *Handbook of Midwifery* are announced for early publication by the House of Cassell.

Lectures on Surgery to Nurses. By Alan H. Todd, B.Sc., M.S. Lond., F.R.C.S. Eng. (Messrs. Edward Arnold, London) 1920.

In *Lectures on Surgery to Nurses* Mr. Alan H. Todd has given to teachers in the Nursing profession a book which cannot fail to lighten their task in correcting notes or collecting material for the Surgical Class. Each chapter is arranged as a separate lecture, and can be delivered, as it stands, in an hour. There are fifteen lectures. The first two contain a clear description and explanation of inflammation, ulceration and gangrene, and the remainder cover a wide field of surgical interest. The whole is dealt with in simple, colloquial language, and nurses are shown how to approach their patients with eyes that see and ears that hear. This book, while being valuable to all nurses, should prove of the greatest assistance to those persons responsible for teaching probationers in small hospitals, where it is not always possible to prepare a consecutive course of lectures.

Notice.

The League of the Red Cross Societies.

Headquarters at Geneva, Switzerland.

A Medical man is required to add to the Staff of the Red Cross Society, a man who has a considerable knowledge of languages, preferably French, Italian or Spanish, to assist in the work of Editing the International Journal of Public Health, which is published in four languages, English, French, Italian and Spanish. He would probably have to translate a comparatively few articles into English; but the major part of his work would be the general supervision of translation which would be done by the League translators of the Department.

Births.

SPENCER-PAYNE.—On June 2nd, at a Nursing Home in London, Sybil (neé Spencer-Payne), the wife of A. Ll. Spencer-Payne, M.R.C.S., L.R.C.P., of a daughter.

SIDEBOTHAM.—On August 15th, at Meonvale, Ashtead, Surrey, the wife of F. N. Sidebotham, of a son.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

VERY little has been heard lately about the War Memorial, concerning which a considerable controversy took place in the pages of the GAZETTE rather over a year ago. The problem which has faced all War Memorial Committees which have had any substantial sum of money to deal with has been twofold. There has been, on the one hand, a party of enthusiasts who have urged that the only real memorial to the dead is a permanent monument serving no other purpose than that of commemorating the lives and deaths of those whose names are inscribed upon it. The opponents of such a suggestion, on the contrary, maintain that a true memorial is one that will serve some useful purpose and which will be of definite service to the institution of which it is desired to commemorate the fallen members; for, they argue, the men who have given their lives would themselves have chosen such a memorial. To this latter suggestion the objection is invariably raised that it is not our place to put in hand structural or other work of which we ourselves have long been in need as a commemoration of those who are now no longer able to benefit by such advantages.

A compromise between these opposing parties is no easy matter. But experience has shown that they are prepared to come together over the question of pecuniary assistance to the descendants of those who have been killed or financially straitened by war service. And so we find that War Memorials at Schools, Colleges, and other educational establishments have practically all taken the form of scholarships combined with some form of compromise between the two forms of tangible memorial to which reference has previously been made.

The Guy's Hospital War Memorial Committee has been no exception to this general rule. Out of seven open scholarships for which competition is invited during the present month there are two War Memorial Scholarships—one junior scholarship in Arts and Science "providing a free medical education for five years," and one senior or University Scholarship "of the value of £80 open to Candidates under 25 years of age who have completed the curriculum for, or passed the examinations in, Anatomy and Physiology for a medical degree in any University of the British Empire."

We understand that the visible memorial is to take the form of a memorial arch to be erected in place of the present gateway into Mazepond. Although we gather that the Committee was unanimous in passing this suggestion and in negativing a proposal for the erection of

some form of Cenotaph in the middle of the Park, we believe we are right in saying that subscribers to the Fund were informed that no definite action would be taken without reference to them through the medium of a general meeting. We regard this question of a referendum to subscribers as of considerable importance. Many people do not feel prepared to subscribe large amounts to a fund which may, for all they know, be used for purposes which they consider highly undesirable. We know of some Guy's men who consider that nothing in the way of building, on however small a scale, should be contemplated until it has been ascertained for certain that there is no fatherless or orphaned child of a Guy's man whose education is threatened by a lack of resources which could be met by contributions from the War Memorial Fund. The financial situation of the families left behind by fallen Guy's men (for they cannot be very numerous) might easily be discreetly examined and we hope that the War Memorial Committee will issue an account of their transactions at an early date together with a discussion of their policy on the questions that we have raised.

THERE was at one time a proposal that a part of the War Memorial Fund should be used for panelling the walls of the College Dining Room. This suggestion fell through owing to the possibility which has recently been referred to in these columns of an extension of the Students' Club premises and the conversion of the present DiningRoom into residential rooms. The warehouse adjoining the College which was (and we hope still is) the proposed site for the new Students' Club is the property of the Hospital and the present lessees are paying a rent of £450 per annum. In the event of this building being acquired by the Students' Club this rent would be a considerable drain upon the resources of the Clubs' Union. The actual cost of conversion has been estimated at not less than £20,000. If the interest on this sum may be reckoned at £1,200 per annum it will be clear that the proposed conversion would involve an annual expenditure of at least £1,650 assuming that the running expenses of the Club could be met by such profits as could be made on catering, billiards and so forth. It is very improbable that such a profit would be realised even under the most skilful management.

It is these financial considerations that have led the Clubs' Union Council to decide that it is unable, single handed, to carry out the enlargement of the Club premises. Under these circumstances the Council has resolved to apply itself to the work of improving the ground at Honor Oak Park, a more modest but equally important task. For the moment attention is being concentrated upon securing better accommodation for spectators at Football Matches. It is proposed to erect two stands with a seating capacity of 100 each on either side of the existing one. At a later date the present large stand, which will hold 300 people, is to be moved further back to allow of a better view of the field and also more standing room between the front of the stand and the touch line. Owing to the existence of the stream which runs behind this stand the work will involve the laying of concrete foundations and a drain to carry off the water which would otherwise become dammed up. The estimated cost of these alterations is something between £2,000 and £3,000.

With reference to the financial position of the Clubs' Union we should like to make a suggestion which if acted upon would, we believe, add a very considerable sum to its annual income. The best football clubs are able to support themselves almost entirely upon their "gates." The possibility of doing this depends largely upon the distinction of the Club in question. The really first class clubs are in a position to insist on all matches being played

on their own ground. This means that the local population, and others interested in the game, get to know that they can always witness the best football at the ground ot that particular club, and so, gradually, a large and permanent gate is secured. Surely Guy's has a sufficiently distinguished Football Club to justify it in insisting on a majority of home matches, and so securing for the ground at Honor Oak Park the reputation for providing lovers of the game with a satisfactory entertainment on Saturday afternoons. This suggestion may seem commercial, but that is not a sufficient reason for failing to exploit a method which we believe would bring a most needed and valuable addition to the revenues of the Clubs' Union.

Not many days ago a notice appeared near the front lodge inviting all students to present themselves in the Colonade (sic!) on a certain day and at a certain time for a purpose of which details could be obtained elsewhere. Later, through the medium of the Evening Press, it transpired that the purpose of this mysterious notice was to summon students to an organised "rag" of a meeting of Miners' Delegates. The organised "rag" is a development of the last year. It was stated in the daily press last winter by one of the officials of the "rag" organisation that their purpose was to bring home to the inhabitants of London the fact that they live in a University town—in much the same way as inhabitants of Oxford and Cambridge are not infrequently reminded of their proximity to a University. The raison d'être of such ragging as occurs at Oxford and Cambridge is certainly far from being that which has been stated to inspire the organisation of rags in the University of London. Moreover, the essence of a rag—at any rate of a really satisfactory one—is its spontaneity Such things are not, and cannot be, organised. If they are, they cease to be rags. We have no objection to ragging quâ ragging. But in the present instance a more important principle is involved. The rag to which we refer had no possible connection with the Hospitals or with the University. It was simply an organised effort to embarrass a party involved in one of the most serious political crises that has arisen since August, 1914. It is not the business of medical students to meddle with such matters by unconstitutional methods. Such a procedure is only another form of that direct action which we presume it was the intention of the participants to condemn. We hope that at Guy's, at any rate, the members of the rag committee will hesitate before allowing the members of their "Union" to be drawn into proceedings which bring discredit upon themselves, their Hospitals and their University.

Congratulations to Mr. E. Biddle on his wedding, which took place in Southwark Cathedral on September 7th under conditions of great secrecy. Perhaps he was wise, for we gather there were several conspiracies on foot to make the event a notable one; and, anyhow, he was following a precedent set by the Superintendent himself!

Papers by Guy's Men.

W. E. Tanner, M.S., F.R.C.S., "Two Cases of Obstruction in the Small Intestine."—*Lancet*, June 26th, 1920.

W. E. Tanner, M.S., F.R.C.S., "A Case of Double Congenital Talipes Varus."—Journal of the Royal Army Medical Corps, July, 1920.

John A. Ryle, M.D., M.R.C.P., On the investigation of Gastric Function by Means of the Fractional Test-Meal.—*Lancet*, September 4th, 1920, p.490.

Appointments.

W. E. Tanner, M.S., F.R.C.S., Assistant Surgeon to the Prince of Wales' General Hospital, Tottenham.

Papers by Old Guy's Men: A Few Suggestions.

BY A. PERCY ALLAN.

THERE was a belief current at Guy's in my time that the "Great and Wise" taught the student everything under the sun but Treatment. Conversation on this point passed almost to a scandal, and at last naturally enough got to the ears of the G. and W. I remember well Sir Frederick Taylor discussing the matter in his best forensic manner (but with some heat) on going round Mary Ward, and he somewhat sarcastically drew his clerks' attention to the writing on the bed-letters. On the assumption that this legend is still prevalent among students, and that they still buy the worthless volumes we did on Treatment, I would offer these short notes, hoping that others may follow me, supposing that the G. and W. are still unregenerate.

Treatment of Short Febrile Conditions.—I have long come to the conclusion that we overfeed these cases. Children, who in many things are more sensible than adults, obstinately refuse food when suffering from such common ailments as influenza, measles, and febrile attacks of the digestive organs. I am convinced from long experience that adults do better if they follow the juvenile example, and take plenty of pulls of cold water. Certainly the period of pyrexia is prolonged in those patients who will "keep their strength up." Of course, in this matter the doctor has to use some tact, and a good introduction to starving the fever is to ask, "Are you hungry?" and on getting the negative to say, "I will not bother you about food." If it is necessary, in order to please the patient and friends, that milk be given, let it be diluted with half and half soda. Very much less will be consumed if tea and fruit (oranges and grapes) be ordered with the injunction that the latter be kept free of the milk feeds to prevent curdling. One of the meat extracts, *made weak*, or Marmite, can be given, and thus the patient saved from being stodged up with milk.

As regards physic, if there is no special symptom to relieve, the best drug to give is Liq. Am. Acet.* with syrup of orange. Pain in limbs or head may be relieved by a dose or two of Acid. Acetyl. Sal., but there is no object in plugging drugs of this character into the patient after distress has been relieved.

Local Treatment in Acute Rheumatism.—In my time at Guy's nothing was done in this respect, but I find the patient gets enormous relief by the application of Methyl. Salicyl. in oil (2 dr. to the oz.). Smear the oil on and cover the joint. It "touches the spot" and reduces the quantity of Sod. Salicyl. required—a beastly drug, as I know from personal experience of three attacks of R.F.

Administration of Quinine.—One of the reasons why patients tell you they cannot take quinine is because it is given dissolved. Patients can take it and not know the fact, if a small dose be dissolved in Spt. Vini Rect., some syrup of orange added, shaken, and then fill up with water. The quinine is precipitated in a fine powder—"shake the bottle." For large doses required in malaria, do not give the beastly stuff suggested by the army authorities, which is worse than the attacks of malaria. Give the quinine in powder, pop it on the tongue and let the patient swallow it with a drink of water. It is very little bitter unless dissolved. For fastidious patients give the quinine in a cachet. Tablets are unreliable, and I have seen them passed unchanged in the motions. If you are ordering the quinine and alcohol mixture be sure the chemist does not add on his own account a few drops of acid to dissolve it, for some of them will do this.

Treatment of Indigestion.—Be sure in dieting your patient that he or she does not continue your diet for life. Remember what Goodhart said: "Indigestion is either due to overeating or to a nervous condition of things." I have never used pepsin in treatment, and never saw it prescribed at Guy's. For some years past I have given up Bismuth, except occasionally. It binds the bowels, which is a great disadvantage. The best drug is Magnesia Emulsion given with chloroform water, to which a little glycerine may be added. It is pleasant to take (give it half an hour after meals) and a drachm to the ounce is sufficient. It has a great advantage over the carbonates, as no gas is formed. With kiddies leave out the chloroform water, but do not forget the glycerine.

Treatment of the O.P. position in labour.—The books tell you to make out the presenta-

*Sir J. Goodhart is my authority, and he ought to be good enough for anybody.

tion, and if O.P. to turn into O.A. This is wise advice and should be acted upon. More often you will find you do not make out the presentation, but you find the head does not come down, and after putting on forceps that they do not lock properly. If you are then fool enough to pull hard they will pull off, and the books tell you will damage the soft parts. This may be so, but I have never seen it happen. Remember, the O.P. position is very common, at least that has been my experience. The turning to an O.A. position is fairly simple as given in the books, the devil of it is that often one does not turn completely and the little beggar slips round into the "as you were" position. I was called by a grave and learned senior to assist him in one of these cases, his forceps had slipped off three times (with no subsequent harm). This happened again with me, and I tried to turn as he had several times done; each time it was a case of "as you were." The following dialogue ensued :—

G. &. L. S. : "We had better do a version."

Myself : "That will not be an easy job with an exhausted mother and such a great baby."

G. & L. S. : "Then what do you propose?"

Myself : "I will have another try rotating and *I will hold the head round with my fingers while I put on the forceps.* If we do a version we shall get a dead baby."

It came off; not the head, but the confinement, quite all right ; but we got a dead baby, a big creature of ten pounds weight. My dodge was, I believe, as old as the hills, but I was pleased with what I considered my originality at the time.

In conclusion, may I call on the next Guy's man for some notes more illuminating than these. I can go on quite fluently, but perhaps the Editor will say :

"' ENOUGH IS AS GOOD AS A FEAST."

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Radiographic Demonstration of the Vermiform Appendix.

BY J. MAGNUS REDDING, F.R.C.S.

ALTHOUGH X-ray examination of the alimentary tract has been widely adopted for a number of years in the investigation of gastro-intestinal disorders, the vermiform appendix has received at the hands of European radiologists somewhat less attention than its importance would appear to warrant. These observers, finding that they practically never saw the appendix during their examinations—in other words, that the opaque meal very rarely entered the lumen of that organ—were forced to fall back on diagnosis by inference, or, as it is commonly called, the indirect method of diagnosis; some even going so far as to state that the intestinal contents did not enter a normal appendix. The "indirect method" of diagnosis was not confined to the appendix, but was applied to all parts of the gastro-intestinal tract, and, with some modifications, has been adopted by the majority of radiologists in this country and on the Continent to-day.

A large number of workers in the United States, however, headed by Cole, of New York, broke away from the teachings of the Continental pioneers, and elaborated what is known as the "direct method" of diagnosis, claiming that, with special technique, they were able to demonstrate any surgical lesion of the alimentary tract in virtue of the deformity which is produced by such a lesion in the outline of the affected viscus. It is not my object here to contrast the merits of these rival methods in their application to the gastro-intestinal tract as a whole, but to show what appears to me to be the obvious superiority of the direct method in investigating the condition of the vermiform appendix, and to detail the necessary technique. It will be well in the first instance to review briefly the method of indirect diagnosis. The adherents to the indirect school rely mainly on the observation of two phenomena for the assumption that the appendix is abnormal—ileal delay and localised tenderness over the ileo-cæcal junction.

1. *Ileal delay.*—At the outset it is necessary to point out that the diagnosis of ileal delay, although it has been, and still is, made with considerable freedom, is yet beset with many pitfalls. The nature of the meal given, and its bulk, the rate of emptying of the stomach, the conduct of the patient on the day of the examination (*e.g.*, whether going about his ordinary business, or confined to a chair or to bed), the taking of, or abstention from, food during the early hours of the examination—especially the

taking of food before the whole of the opaque meal has left the stomach; all these and many other factors produce profound modifications in the time at which the small intestine will be free from opaque contents. Disregard of these factors will inevitably lead to fallacies in diagnosis; due consideration of them will result in a marked reduction of the number of cases relegated to the category of ileal stasis. Possibly the best criterion of the presence or absence of ileal delay is afforded by the length of time which elapses between the commencement of emptying of the stomach and the commencement of filling of the cæcum; if this observation is utilised some fallacies at any rate are eliminated, although many potential sources of error still remain. Where true ileal delay is shown to be present, its causation may be (a) neuro-muscular defect (*e.g.*, spasm, or failure of normal relaxation, of the ileal sphincter, or inhibition of the normal ileal peristalsis) or (b) mechanical obstruction (*e.g.*, by adhesions, bands, or pressure from without). Only such abnormalities as are shown to produce definite narrowing of the intestinal lumen should be accepted as causing mechanical delay; cases which can safely be included in this category are quite rare.

It is upon the neuro-muscular factor that the adherents of indirect diagnosis rely chiefly for providing evidence of an appendicular lesion, on the assumption that such a lesion causes spasm of the ileal sphincter. As a matter of fact, however, no constant relation can be shown to exist between the condition of the appendix and the rate of passage through the ileum. Presumably an acute appendicitis is associated with some degree of paresis of the small gut, with consequent ileal delay, but the acute abdomen is, for obvious reasons, rarely seen by the radiologist. Sub-acute and chronic lesions of the appendix sometimes co-exist with a perfectly normal rate of transit through the ileum, while severe degrees of ileal delay are frequently unassociated with any abnormality of the appendix; moreover, at second examination of a certain number of cases in which ileal delay had co-existed with an appendicular lesion, I have been unable to show that appendicectomy has resulted in any appreciable diminution of this delay, although complete relief from symptoms has ensued. These re-examinations have been made at intervals varying from a few weeks to a year after operation, but the time factor has not apparently influenced the result.

The cases which have been examined in this way up to the present, however, are not sufficiently numerous to justify any dogmatic statement.

2. *Localised tenderness over the ileo-cæcal junction.*—This constitutes the second observation upon which stress is laid by the adherents of indirect diagnosis, but is also open to criticism as applied to the recognition of appendicular lesions. Tenderness more or less localised over the ileo-cæcal junction is commonly present in cases of ileal delay from whatever cause arising; this tenderness was a prominent feature in the examination recently of several patients from whom the appendix had been removed long ago. Moreover, where a diseased appendix is demonstrated by the direct method, tenderness, if present, is generally most marked over the appendix itself.

Enough has perhaps been said to show that the indirect examination of the appendix is far from satisfactory, and this contention receives tacit support from the members of the indirect school themselves, in the very meagre attention which they bestow upon this organ in their descriptions of opaque meal procedure.

For examination of the appendix by the direct method it is essential that the appendix be actually seen, or in other words that the lumen be filled by the opaque material given in the meal. Whether this end be attained or not depends very largely upon the preparation of the patient and the nature of the meal given.

As regards preparation, the patient must take an aperient (preferably castor oil) twenty-four or thirty-six hours before the meal; the ordinary food is taken during the day prior to the examination, but the first visit to the radiologist should be made with the stomach empty. The patient should, therefore, abstain from breakfast entirely, or at most have a little toast and tea on first waking.

The opaque meal consists of an emulsion of pure barium sulphate (4 oz. for an adult) in ¾-pint of buttermilk. If buttermilk is unobtainable, plain water appears to be equally suitable as regards the filling of the appendix. Buttermilk, however, forms a more permanent suspension of the barium, and this is of advantage in making a direct examination of the upper part of the gastro-intestinal tract. The patient is examined at once, and at four, six and twenty-four hours after the meal, or more often if it is necessary to confirm any abnormality noted in the appendix (see below).

After the second examination the patient is permitted to take a light meal. If the appendix has not been seen at the end of the twenty-four hours, the aperient should be repeated, and a second meal administered. Any deviation from this technique will result in almost certain failure to demonstrate the appendix. This organ hardly ever fills when a meal containing cereal is taken, and only fills in about 20 per cent. of cases if ordinary milk is used as the medium for suspension of the opaque salt. The reason for this is unknown, but the fact is well established.

If the technique outlined above be adhered to, the appendix will be filled at one or more of the examinations in a very large percentage of cases.

George and Leonard, of Boston, who have examined a very large number of patients by the direct method, claim that a normal appendix is filled in every instance, and regard failure to demonstrate the organ as evidence of abnormality. This statement requires further confirmation, however, before it can be accepted in its entirety. The sixth and twenty-fourth hour examinations are those at which the appendix is most commonly seen. The patient is examined in the horizontal position, and very careful screen and plate work is essential. At the sixth hour difficulty may be experienced through overshadowing of the appendix by opaque material in the terminal ileum, but this portion of the gut can often be pushed out of the way. If the appendix is observed on screen examination an attempt should be made to determine:

1. Whether or not filling is complete.
2. Regularity of the lumen.
3. The presence of abrupt kinks.
4. The degree of mobility.
5. Localised tenderness on pressure over any part of the appendix.

The patient should be slowly rolled from side to side while under screen observation, so as to obtain the best possible view. In this way it will frequently be found that apparent sharp kinks in the appendix are in reality quite gentle curves, which give the appearance of angulation when viewed in profile. One or more radiograms should always be obtained in whatever position seems most advantageous. If it is found necessary on fluoroscopy to displace the cæcum or lower ileum by palpation in order that an unobstructed view of the appendix be obtained, a pad of cotton wool may be substituted for the gloved hand while the radiogram is being secured, pressure being applied to the pad through the plate.

The radiogram should be examined with regard to points 1, 2 and 3 mentioned above. It is of importance to remember that a plate will often reveal an appendix which fluoroscopy fails to demonstrate. There are two circumstances which render the appendix exceedingly difficult to identify:

1. Retro-cæcal position of the organ.
2. Ptosis of the cæcum into the true pelvis.

The retro-cæcal appendix may be shown by means of a lateral radiogram, or, if this fails, may be seen *through* the cæcum when the latter has evacuated some or all of its opaque contents.

In cases where the cæcum is deeply ptosed, every effort must be made to displace this viscus into the iliac fossa. This end may be attained by palpation in the supine or right lateral position. Should this attempt prove unsuccessful, the patient should assume the genupectoral posture. Perseverance is generally, but not always, rewarded by success.

The Normal Appendix.—Filling probably commences as a rule soon after the opaque material first enters the cæcum. Filling and emptying is accomplished by means of peristalsis and anti-peristalsis. The emptying of the normal appendix commonly synchronises with the evacuation of the cæcum, but sometimes the appendix fills and empties again while the cæcum still retains its opaque contents. In this way a certain number of failures to demonstrate the appendix can probably be accounted for, filling and emptying having taken place between two observations—an argument in favour of more frequent examinations where this is practicable.

The normal appendix fills completely, and its lumen is perfectly regular. The width of the lumen varies in different subjects from about $\frac{1}{32}$ in. up to $\frac{1}{4}$ in. or even more. Multiple physiological constrictions, producing a segmented or beaded appearance, are very commonly present, but are so characteristic that they are unlikely to confuse the diagnosis (Figs. 3 and 4).

Free mobility is demonstrable, and the appendix can be readily separated from the terminal ileum. There is no tenderness localised to the appendix, though diffuse tenderness may be present as the result of some lesion other than appendicitis.

The Abnormal Appendix.—Persistent incomplete filling and irregularity of lumen form the basis upon which a diagnosis of abnormality is founded. The radiologist must satisfy himself that these defects are constant, otherwise a normal appendix seen in process of filling or emptying may be considered pathological. Every degree of defect is encountered, the more striking examples being commonly associated with an appendix which has suffered long-standing or recurrent attacks of inflammation; the extent of the abnormality is no index to the clinical severity of the lesion. Concretions are readily recognised. They produce rounded or oval filling defects which look somewhat like bubbles of gas; they do not usually cause complete obstruction to the passage of the appendicular contents.

Subsidiary factors in the diagnosis of abnormality are:

1. Kinking. This can hardly be regarded as a pathological condition, whatever its potentialities may be, unless it is accompanied by definite irregularity or constriction of the lumen, by incomplete filling, or by prolonged retention of contents distal to the kink. This retention of contents is a common phenomenon in all lesions of the appendix, and has sometimes been seen to persist for as long as three weeks after the meal.

2. Defective mobility. This is fairly frequently present, and, if it can be conclusively demonstrated, is of considerable importance. It is often, however,

difficult or even impossible to determine the degree of mobility present, owing to resistance of the abdominal muscles.

3. Localised tenderness on pressure over the appendix. Sometimes a perfectly definite "tender-point" can be found on pressure over some part of the appendix; more often tenderness, when present, is too widely diffused to render definite assistance to the radiologist.

To sum up, then, it may be stated:

1. That in a very large percentage of subjects the appendix can be demonstrated by the adoption of correct technique.

2. That a normal appendix will always give a normal appearance during some part of the examination.

3. That a pathological appendix will show a *persistent* defect in filling or in the regularity of its outline.

4. That in the presence of the above abnormalities acute kinking, prolonged retention of contents, defective mobility, and localised tender-points on pressure, afford valuable confirmatory evidence of an appendicular lesion.

Two Cases of Cerebral Tumour.

J.W., æt. 48, a carpenter, was admitted to Addison under Dr. French on July 23rd, 1920, suffering with severe headache and left-sided hemiplegia.

He has for some years suffered from very severe headache and bilious attacks, but he dates his hemiplegia from a blow on the back of his head about a year ago. The hemiplegia has been of slow onset, and at times is much worse than others. Lately he has been troubled by severe pains in his right occipital region. At the same time he also vomits a great deal. This vomiting appears to have no relation at all to food. His speech has grown slurring lately.

Physical examination reveals nothing in his circulatory, respiratory or alimentary systems except the fact that his pulse is habitually slow, about 45. His blood pressure is 160 mm.

His eyes react normally, and there is no nystagmus. All movements are well carried out. His arm and abdominal reflexes are present, and equal knee and ankle jerks are present on both sides and show no definite difference in intensity. On the right side there is a flexor plantar reflex, but a definite extensor one on the left. There is no ankle-clonus.

There is some weakness of the whole left side, better seen in the face, where a typical upper neurone lesion is indicated.

Cerebro-spinal fluid is not under pressure, and shows no increase in cells or protein.

The Wassermann of both blood and cerebro-spinal fluid is negative. There is no sign of optic neuritis.

At this time a vascular lesion was thought to be most probable, a thrombosis of some cerebral vessel.

August 8th.—To-day he had an extremely severe headache, so a lumbar puncture was performed. Fluid was drawn off, but not under pressure, and did not seem to give any relief. His blood pressure at this time was not raised, and he was quite conscious but somewhat dull mentally.

Next day he became somewhat worse. His temperature and pulse began to rise and his blood pressure to fall. He ceased to respond when spoken to or would only do so after a long latent period.

His breathing became very stertorous, and he developed many moist râles in his chest.

There were at no time any localising signs during this attack, and all his reflexes remained as before. His pulse mounted until it was uncountable, and his temperature rose to 106°, while his blood-pressure fell to 110 mm. just before death.

At the post-mortem a large tumour about three inches by two by two was found in the third ventricle attached to the under surface of the corpus callosum and to the choroid plexus. It had a very nodular appearance, each nodule being about the size of a small grape.

Microscopically it had the appearance of a psammoma, and probably originated in the choroid.

As it was freely movable in the ventricle, it was suggested that it might have fallen back and blocked up the opening of the Sylvian aqueduct, and so produced the terminal symptoms. This might also have accounted for the absence of pressure found in the spinal canal.

The second case was that of a gardener of 32 who was admitted on Agust 11th.

He gave a three months' history of giddiness, which first came on quite suddenly and without predisposing factors. He states that things seemed to swim before his eyes. Since then he has had many severe attacks with headache situated over the middle of the right parieto-frontal suture and behind the right eye. Occasionally he has had diplopia.

He shows signs of a left hemiplegia chiefly manifested in the facial muscles. The left limbs are

SUPPLEMENT TO

"Guy's Hospital Gazette,"
September 18th, 1920.

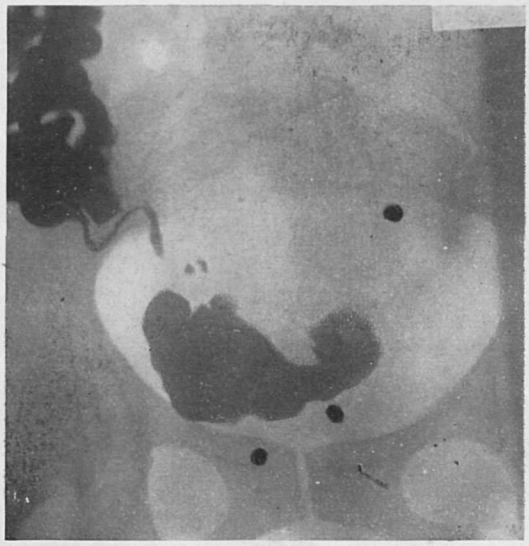

Fig. 1.—Long normal appendix. The apparent angulations were readily straightened out by palpation.

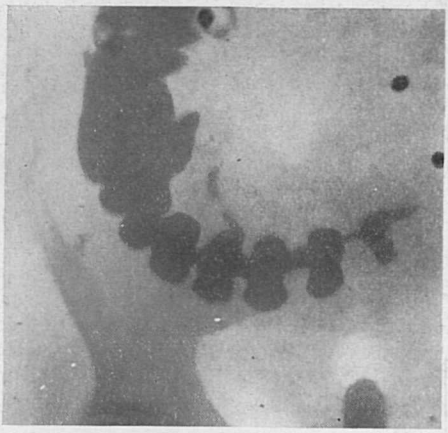

Fig. 3.—Normal appendix showing physiological constrictions.

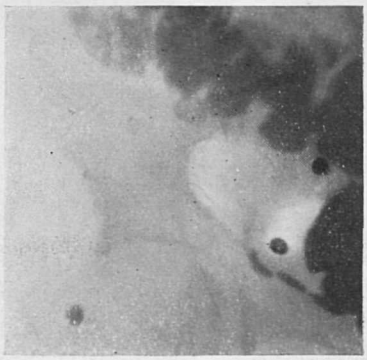

Fig 4.—Apparently normal appendix lying to the outer side of a ptosed cæcum. Physiological constrictions are well marked. The distal extremity of the appendix has commenced to empty but sufficient opaque material remains to demonstrate a normal lumen.

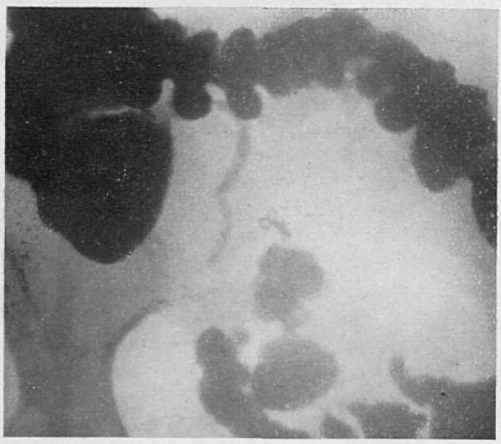

Fig.2.—Very long normal appendix. The apparent angulation was readily straightened out by palpation, and it was then found that there was no constriction at this point.

Fig. 5.—Chronic inflammatory changes. There is acute kinking, with obvious narrowing of the lumen at this point. The lumen throughout shows irregularity, and it was impossible to move the appendix apart from the cæcum and ileum on palpation (confirmed at operation).

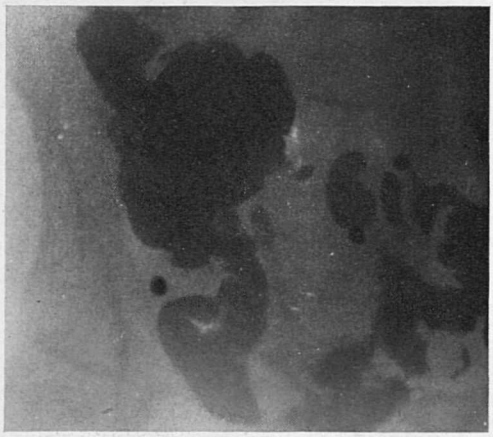

Fig. 6.—Chronic inflammatory changes. There is defective filling and irregularity of the lumen (confirmed at operation).

Fig. 7.—Chronic inflammatory changes. There is very marked irregularity of the lumen. Palpation was resisted, so that the degree of mobility could not be determined (at operation a sub-acute appendicitis with abscess formation was found).

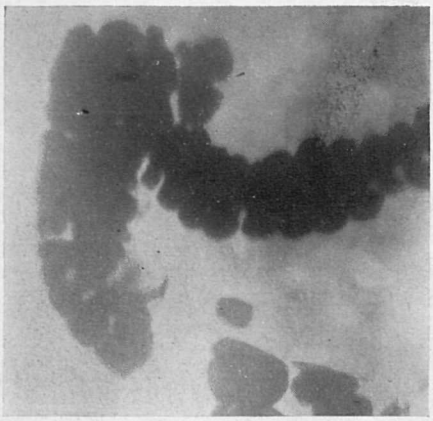

Fig. 8.—Chronic inflammatory changes. The base of the appendix only is filled, and there is a suggestion of acute kinking at the limit of filling. Fixation and localised tenderness on pressure over the base of the appendix were observed (operation revealed a chronically inflamed, adherent, and kinked appendix, associated with a duodenal ulcer).

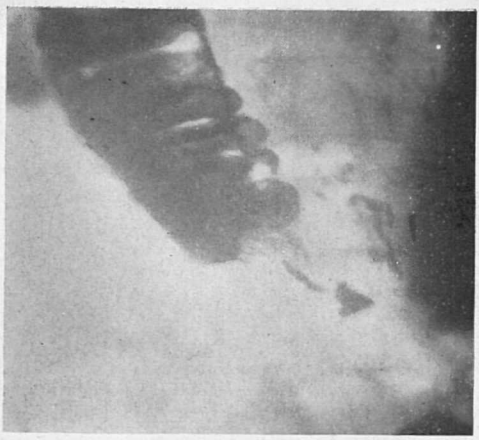

Fig. 9.—Chronic inflammatory changes. The proximal half of the appendix shows constriction and defective filling.

Radiographic Demonstration of the Vermiform Appendix by Mr. J. MAGNUS REDDING, F.R.C.S.

weaker than the right, and the jerks are all less on the left side. The abdominal reflexes are normal. Eyes react and move well, and there is no nystagmus. The fundus shows a typical choked disc with very much œdema extending outwards almost to the macula.

On examination it was found that he got diplopia when he looked upwards and outwards to the right, and on application of the candle test this corresponded to a paralysis of the right inferior oblique.

Cerebro-spinal fluid was not under pressure, and showed on examination no increased protein. Wassermann to blood and fluid was negative.

August 15th.—To-day he had a severe headache and marked diplopia, with ptosis corresponding to paralysis of all the muscles supplied by the right third nerve. The right pupil was also much larger than the left, and there was much nystagmus. The weakness of the left side of his body was also very much increased, and he now had a very definite tremor of his hands. Babinski's reflex became at this time very definitely extensor, and ankle-clonus was demonstrable on both sides. He vomited many times. Blood-pressure was 190 mm. as compared with 110 on admission, and his pulse rate was 50. Lumbar puncture gave clear fluid under much pressure. There was again a slightly raised protein value. After the lumbar puncture he became much better for a time, but on the symptoms again getting worse it was decided to operate.

Novocaine was injected into the scalp. A subtemporal decompression on the right side was performed. Much intra-cerebral pressure was found, and any attempt to localise the tumour was rendered impossible by it.

After the operation his pulse rate increased to 130, and he lost consciousness. His blood-pressure was 110, and it rose slightly before he died some eight hours after the operation. It was expected that a tumour somewhere in the neighbourhood of the right crus would be found, as it seemed probable that the nucleus of the right third nerve had been affected, while the fibres descending from the right motor cortex had been involved prior to their decussation. The fact that a tremor was present seemed to point to something near the red nucleus. This location would also account for the optic neuritis.

At the post-mortem a round, encapsulated tumour was found in the cerebral cortex about two or three inches behind the right Rolandic area and encroaching upon the longitudinal sulcus. It was about a couple of inches across, and shelled out very easily. Structurally it was a glioma.

A. McK.

Child Welfare.*

WRITING on economic development from Christ's College, Cambridge, Mr. C. R. Fay closes his chapter in a recently published series of essays by saying:—

"In all the industrial movements we have described, the spiritual stimulus, the initial drive, and the solid successes have been provided by voluntary association. The State has not been the pioneer of social reform. Such a notion is the mirage of politicians. It has merely registered the insistent demands of organised voluntary effort or given legal recognition to accomplished facts."

To the truth of this statement Dr. Lane-Claypon bears testimony in her book on the "Child Welfare Movement."

Honour is paid and thanks given to the pioneer voluntary workers of this now widely spreading organisation. A beginning is always made by the few to whom some existing need has made a strong appeal. In this case it was the pitiful condition of infants and young children and the high death rate which resulted. In the early sixties the Manchester and Salford Ladies Health Society endeavoured to counteract the unhealthy conditions of the poorer dwellings by employing women visitors to give simple and helpful hygienic advice for the homes in general and for the infants in particular.

This created a demand for the knowledge of the whereabouts and birth of infants, which eventually resulted in the Notification of Births Act and to the ultimate acceptance by the national conscience (expressed through public bodies) of duty and responsibility to the least of its members.

In France the movement commenced with Professor Budin's "Consultation des Nourrissons" to encourage breast feeding—the first Infant Consultations—and in Belgium "Schools for Mothers" were opened, and the movement spread into the Western nations of Europe.

These facts are merely introductory to Dr. Lane-Claypon's most admirable work, a handbook, as she states in her preface, for those who wish to understand something of the machinery for the conduct of work for maternity and child welfare and the training for and opportunities for service which present themselves.

She pleads with the workers for a wide vision, as the circles of influence and activity are ever spreading. The infant from birth to one or two years cannot be treated alone, and so the book deals

*_The Child Welfare Movement_, by Janet E. Lane-Claypon, M.D., D.Sc. (Messrs. Bell & Sons); August, 1920, price 7s.

with its pre-natal life, the mother, the whole question of the midwifery service, the Welfare Centres, and the day and school nurseries, and the interdependent life of the whole community.

The attention of the Health Visitor is drawn to the essential value of an intelligent and personal co-operation with existing charities and social organisations, and a knowledge of the powers and duties of all local authorities. Of her visitors Dr. Lane-Claypon expects a high standard of thoughtful efficiency and a boundless sympathy with the conditions under which most of the poor mothers live—"those Madonnas of the slums." The sympathetic note is stressed, and she would have each one of us feel responsible for our part in poverty.

On two counts the book is of special interest to Guy's men and women. Those who read the five chapters on midwifery and pre-natal work will see that Dr. Lane-Claypon is at pains to discuss the unsolved and difficult problem of the position of the Health Visitor regarding pre-natal work and her relation to the doctor or midwife engaged for the confinement, and it is well known at the close of the natal period the parting advice given by the midwife may not be favoured by the oncoming visitor, with resulting confusion. At Guy's we are in an enviable and unique position, as the complete cycle of the work lies in the same hands, pre- and post-natal, *and the midwifery*, with the Centre for the prevention of ills and the Hospital for their cure.

Guy's nurses should read this book, as in the near future there will be many openings under the Ministry of Health.

The ordinary Hospital training gives many valuable qualifications, but by no means all that are required by the Health Visitor. The Board of Education has recently issued regulations for training at institutions connected with a University, and the course for the trained nurse is one year, for other women two years. There is every reason to hope that the nurse training schools may include this curriculum in their three or four years' training, and obtain recognition from the authorities. The present regulations only ask for "some acquaintance with maternity work," but all the Guy's nurses realise the value of their hard-earned Midwifery Certificate, and Dr. Lane-Claypon herself says "no training gives so close an acquaintance with the difficulties of the working mother as the midwifery training when taken on the district."

Here is an encouragement and an incentive to enter a great and beneficial national service for which Dr. Lane-Claypon's book is an inspiring guide.

F. A. SHELDON.

Guy's Hospital Maternity Charity,
St. Thomas's Street, S.E.1.

Notes on an Epidemic of Influenza.

BY W. BURRIDGE.

WHILE I was in medical charge of the Prisoners of War Labour Camp at Kantara, influenza broke out in one of the five compounds. The available accommodation for isolation of contacts being at that time wholly occupied by eye cases, each man reporting sick with influenza was sent forthwith to hospital irrespective of the severity of his symptoms. After five days the daily incidence had risen to twenty, and sixty had been sent to hospital. To avoid overcrowding the hospital and to limit the area of the disease it was then decided to place the compound in quarantine. Thereafter only severe cases were sent to hospital, and the mild ones were treated on the spot. The disease went through the compound in the usual way, and then died out.

Next it appeared in compound No. 3 situated about 100 yards from the former (No. 2), but down the prevailing wind. Exactly the same procedure was adopted as in the former case, and with similar results. The disease was limited to the compound, but practically everybody in the compound got it.

To limit the disease successively to single compounds in this manner was in itself highly important, as it avoided any grave dislocation of labour such as might have interfered with operations further up the line. The next compound to be attacked (No. 4) was attacked at a time when every available labourer was urgently needed, and to place it in quarantine with the resulting making non-effective of about 800 men might have had serious results. On the other hand, it was important that potential carriers of such an infectious disease as influenza should have no opportunity of disseminating it elsewhere. Hence some other mode of procedure had to be adopted.

The prompt isolation of those who felt ill enough to report sick had limited the disease to one compound at a time, but had been quite inadequate to prevent spread of the disease within the compound. It was thus possible that the people who spread the disease were those who had it and did not feel ill enough to report sick. The only opportunity of getting hold of such was at the evening count-parade, and the whole time available was thirty minutes. To examine 800 men in thirty minutes was difficult, but by a proper division of labour it was done.

I had five medical officers available for the inspection, which meant that not more than 12 secs. were available for each individual examination.

Hence they were instructed not to ask any questions, but by feeling the pulse without attempting to count, looking at the man's tongue, and from his general appearance to decide whether the individual was "off colour" or not. Question and answer would have absorbed at least two of those ten seconds and would have been superfluous because we were not accepting the individual's own estimate as to whether he was well or not. Once the medical officer decided that an individual was "off colour" that man was sent forthwith to a subsidiary parade where the medical orderlies were in waiting with the thermometers. Each individual with a temperature of 99° F. or more was sent to hospital. The number sent was 35, whereas only five had reported sick that same morning with the complaint.

That ended the epidemic, for there were no more cases of influenza after that inspection. The result showed that the numbers who were ill were greatly in excess of those who felt ill enough to report sick, and the probability that those who spread the disease were those who carried on.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Reminiscences of Guy's Rowing and others.

DEAR SIR,—All old Guy's rowing men will be very pleased to see the revival of the Hospital Rowing Club this year, and hope that the Inter-Hospital Cup will come again many times to Guy's.

It is particularly gratifying to us to see two men in the boat who are sons of members of the Staff and who both rowed for their college at Oxford.

Congratulations to Dr. Shaw and Sir Alfred Fripp on providing Guy's with two first-class oarsmen. I saw Fripp rowing this year at Henley in the Christchurch boat, which won the Ladies' Plate, and he has not won his last boat-race by a good many.

Following on the letters of Sir George Savage and Dr. Walter Swayne in your issue of August 7th, I can supply a few details that may interest those who care for antiquities.

The revival of the Guy's Rowing Club in 1887 was due to the keenness of A. G. Bowen and particularly of Walter Swayne, whose persistence in the matter of getting crews down to the river was relentless. Had there been no Walter Swayne I think we should have fizzled out. He never left us alone.

Mr. Williams, the courteous little gentleman with the silvery beard, who was Clerk to the Treasurer, dug out of the Hospital strong room a silver challenge cup or shield or something which had been presented by someone in bygone days as a Challenge Prize for pair-oared boats for competition amongst Guy's men.

Walter Swayne immediately organised a revival of the Competition, I think in 1888, and by his doggedness inveigled a good entry of competitors, many of whom were by no means polished oarsmen, but were out for a bit of sport in any direction. The race took place at Putney in half out-rigged clinker-built boats. We drew for partners, but I cannot remember who won it. There were no prizes to keep, and I do not think the names of the winners were ever engraved on the Challenge Prize, but I should say there were 9 or 10 entries which were rowed in three heats.

The winners of one heat were George Pender Smith, stroke, and Harry Jordan, bow, who had a neck and neck struggle and won the heat by about two feet. I well remember Jordan lying at full length in the dressing room after the race in the last stage of collapse. He has long since gone to his rest, and although he was at that time one of the prettiest and most dangerous three-quarter backs who ever played for Wales, he was never a trained man.

The crews were called on for the final heat, and Jordan stated in plain and emphatic language that he was incapable of rowing the course again, and the wealth of nations would not induce him to attempt it. It was not put in quite that language, but it was meant to convey that idea.

Pender Smith, who came from Australia, and whose vocabulary was also exotic, shouted at him to get off the locker at once and come and row the final heat, but Jordan told him he could go and row the something boat himself, and he wished him the best of luck. Pender Smith turned to us in despair and said "Mutiny, by God." They did not row.

Where is this challenge thing? Cannot it be found and competed for? There is nothing like pair-oared rowing to teach watermanship.

With regard to the inter-hospital races, we were beaten in 1887 by Middlesex, who won the final.

In 1888 we had bad luck, for E. M. Pilcher (now a very distinguished Colonel in the R.A.M.C.) was kept up at Cambridge, and we only knew he could not row four days before the race. Walter Swayne came in at bow, quite untrained and with a large raw where he sat down, about which he never said a word and of which we knew nothing till after the race. We were three lengths ahead at one time, but were interfered with by a passing steamer, and lack of training told its tale, so that we lost to George's by three-quarters of a length, Bart.'s being third. In the dressing room afterwards we noticed Swayne's shorts soaked with blood, and on investi-

gation found he had the largest and worst raw I have ever seen from rowing. There are very few men who would have rowed with it, and he not only rowed with it but never said a word about it lest we should not let him row.

After this we rather fancied ourselves, and thought we should like to have another run for our money. We heard of a four-oared best boat, built to take a coxswain, for sale, and after consummate bargaining secured it for £5. We congratulated ourselves on this knock-out price, and entered for a Junior race at Molesey Regatta. It was all done in a great hurry, and we paid for the boat out of our own pockets with great difficulty. I know one, and I think two, microscopes went down to the corner. Stanley Worts could not cox us, and we borrowed the Middlesex cox, Edward Madge, to take his place. We had only a couple of outings in the boat before the race, and Madge, who was probably the best cox up at the Hospitals in those days, had considerable difficulty in steering the boat. We then examined it critically, and found that by the action of the sun or some other agency it had become warped into a semi-lunar shape, and tended to go round in a circle. This explained the price. However, we elected to race, and race we did, with Teddy Madge hanging on to one rope of the rudder with both hands. Even then he had to easy the stroke side now and again to get the boat out of the bank and into the fairway again. This happened at intervals, and we did not win.

You know that was an enterprising period at Guy's, and a lot of things were started at that time. Besides the College, the Clubs' Union, and Athletic Ground, there were the Students' Club, the Gymnastic and Boxing Clubs, which had their genesis in those years in the old Mary's ward, then closed, and looking back it is doubtful if the Clubs have ever been more healthy than they were then. My old friend, Dr. Samways, wrote to you some little time back about the rows we had about the catering in the Club, and how he defeated Sir Alfred Fripp and myself on the subject of the Caterer. It was so, but I believe that Dr. Samways, with his fiery eloquence, removed the best Caterer the Guy's Students' Club ever had or ever will have—our old friend Henry Milson, landlord of the Ship and Shovel. He has lately gone from us, and left only regrets amongst so many friends who knew him as a big-hearted, honest fellow, who was out to do his utmost for any and every Guy's man.

There are hundreds and hundreds of Guy's men who, like myself, will always feel one of the kindliest associations of their student days bound up with Henry Milson, as a man who always stood by a Guy's man, and pulled up and helped many a weak one who was kicking over the traces.

One of the back wards was given us as a gymnasium, and there we got some gloves and started knocking each other about. We then engaged Professor Bill Natty, who kept a boxing saloon in the Boro, to come and teach us, and we got a useful team together.

Then the College and Pavy Gymnasium was built, and we moved over there and had a roped ring. Competitions were held at the opening of the Gymnasium, to which most of the Staff came. How well I remember Arthur Durham, then Consulting Surgeon to the Hospital, making a speech to thank Dr. Pavy for the magnificent gift of the Gymnasium, in the course of which he began to take off his coat, and said, "Come on, Pavy, I challenge you to three rounds."

In the novices' middle-weights, there was an exciting slogging match between C. E. Michael and Farnfield for about two minutes, when Farnfield got in the way of a right swing and went down, hitting the floor hard with his head. That gym. floor is cement under the parquet, and does a head no good on contact. He was picked up dazed, and helped out, and later on he was seen by two or three of the Staff, and found to have a pulse of 42. He was warded and watched carefully. For a fortnight he lived on Epsom Salts and slops, but his pulse only fell to 40. Michael slept badly, became depressed, and exhibited a tendency to hide himself; we were all of us subdued, and a cloud hung over the smoking-room. Farnfield had to put off his second conjoint, which was due then, and as he felt perfectly well, he was only kept in bed with great difficulty. It was an anxious time. His people, who had been written to about his condition, told their family doctor, who thereupon wrote up to say that the boy's pulse had never been more than 44 ever since he had known him. Thus the tension was relieved, and Farnfield, who had never before known about his slow heart-beat, was let go, and was not only the most annoyed but the hungriest man in the Hospital until he had righted matters.

We restarted the Inter-Hospital Boxing Competition, and won it, and some of us went for open competitions, with varying success.

Among other instructors we had were Ted White, who beat the Coffee Cooler, and Professor Newton, who now runs a successful school of arms in the West-end.

It is doubtful if Guy's ever had a better Rugby team than in 1887-88, although we were beaten by Thomas's for the Cup by a dropped goal to a try on one of our very off days.

It was a year which, in a way, marked an epoch—not only in Guy's football, but in Hospital football altogether, in London. Alfred Fripp was Captain, and the year before, when he was Secretary,

he arranged a card of fixtures which had never been attained by any hospital before. No one who has not experienced it knows how difficult it is to get fixtures with the crack clubs, and how Fripp did it no one knew. I have heard the same remark about him with regard to many things since then, but this was when he was in his third year, and was an early indication of how he was going to get big things done. We had a Northern tour, and on the Saturday played Bradford, who was the leading club in the North, and got a good beating from them, and on the Monday played Wakefield Trinity, who won the Yorkshire Cup that year, and only beat us by a goal to a try. We beat Blackheath and the London Scottish, when both were at their best, and lost to Oxford, but beat the Cambridge Wanderers, a vacation team of the University.

We had four men in the team who were, or subsequently became, Internationals, and one who played for the South. But the fixture list that year was a distinct lift for Hospital football in London, and was reflected to other hospitals—notably to St. Thomas's, who beat us for the Cup and who were in the front rank of first-class football for some years after. They had at that time two of the best International forwards who ever played—Dewhurst and Goodhue.

The Football Club had some great smoking concerts in those years, the last two being held at the Holborn Restaurant and the Freemasons Tavern. Jackson Lang got together a wonderful programme for each, and many of the best variety artists of the day came to give us a turn, including such favourites as Charles Coborn, Charles Collett, Fred Story, and Dutch Daly.

The one at the Freemasons Tavern was attended by eight hundred men. We broke up at 3 a.m., and the bill for breakages came to £45, so the concerts were given a miss after that.

When one commences to reminisce it is difficult to leave off, but it is quite time I did.—Yours sincerely,

A. ALLPORT.

P.S.—I have looked up my old volumes of the GAZETTE and find in the issue May 12th, 1888, the following under Rowing:—

> "The races for the Challenge Prizes, the silver sculls, presented by T. Galloway, Esq., Junr., and the silver gilt oars for pair oars, presented by J. Benson, Esq., will take place on June 28th, and we hope to see a good number of competitors come to the post."

I can, however, find no subsequent record of the races. That for the sculls did not take place, but the pairs certainly did. The prizes must be somewhere in the Hospital.—A.A.

9, Charles Street,
St. James's Square, S.W.1.

The Selection of the Anæsthetic.

DEAR SIR,—Our thanks are due to Dr. Francis Shipway for the most useful survey of the various anæsthetics in use at the present day, which you have just published. His lecture will be appreciated far beyond the walls of the Hospital.

It would be interesting to know Dr. Shipway's opinion of the routine administration hypodermically of atropine to nasal cases before operation. I have been asked to give this occasionally by surgeons, and the benefit has been almost as great to the anæsthetist as to the surgeon. Instead of noisy, bubbling, obstructed respiration, one gets quiet, soft breathing due to the drying up of both nose and mouth.—Yours faithfully, M. ASTON KEY.

Southsea.
8th September, 1920.

Leprosy in England.

DEAR SIR,—I should be so glad if you can in any way interest the Hospital in our work here. Like the rest of the world, we are nearly bankrupt, and yet each year we realise more the necessity of a leper hospital. We can only take in seven patients at a time, and ought to build, as we are always overful. Five have died here, and we are in touch with a considerable number of cases outside, and are much afraid we shall have still more cases from the Army and Navy, as the disease develops very slowly, and is also frequently diagnosed incorrectly in the first stages.

There is absolutely no other place for the unfortunate patients to go, and they suffer untold mental distress from the thoughtless cruelty of others and from the horror attached to the name of "leprosy."

At present an old Guy's man is acting as our visiting medical officer, and I am proud to claim Guy's as my school.—Yours faithfully,

Sister-in-Charge,
P. S. H. DU BOULAY,

Moor House,
St. Giles' Homes for British Lepers.
East Hanningfield, Essex.
September 15th, 1920.

Reviews.

The Shibboleths of Tuberculosis. By G. Marcus Paterson, M.D. (Messrs. John Murray, London) 1920; price 10s. 6d. net.

This book is as interesting as its title is intriguing. This is fortunate, for if one is induced to look into a book in order to find out what its title means and learn thereby that it does not mean much or that the title has no special relation to the subject matter of the text, one's disappointment may have fatal results—to the book. In this case, however, before you have time to find out by reference to the book, the dictionary and the Bible, that there are no "Shibboleths" of tuberculosis—and cannot be if the definition of the term set out on the title pages is correct, since there are no Parties in Medicine—you are so interested in what Dr. Paterson has to say that, title or no title, you decide to read the book through to the end. Dr. Paterson sets out in the table of contents and again at the head of each section a concrete statement with regard to some points in the pathology, diagnosis, prevention or treatment of consumption, which he proceeds to criticise upon the basis of his own experience. A great many of these statements would at once be controverted by any medical man of experience and common sense. Most of them have probably been held by some doctors at some time, some of them

are possibly held by some doctors at the present time. One is not quite certain after reading the book that some of them are not held, in perhaps a modified form, by Dr. Paterson himself.

The form of the book enables the author to bring various interesting questions very clearly before his readers, and the concrete statements embodying erroneous notions form useful texts for sermons inculcating notions more in conformity with truth. This book is probably intended for, and will at any rate be read by, many non-medical persons, consumptives and their friends, and others. It will prove as useful to them as it will to doctors generally and to those specially who are working at tuberculosis. As a book to be read by laymen, its form has some obvious disadvantages, and it is to be hoped it may not be generally adopted in the increasing number of books that in the future medical men will write for public reading. The form encourages the method of public enlightenment that the medical correspondent of the *Times* has in recent years made peculiarly his own. It is a common fault of reformers to paint the conditions they are out to reform in the blackest colours in order that they may encourage a greater desire to secure an improvement. Dr. Paterson and the medical correspondent of the *Times* paint the ignorance and erroneous notions of their medical colleagues in very deep shadows in order that they may thereby secure high contrasting lights, the former on his own views on tuberculosis, the latter on what he is pleased to call the New Medicine. If we all were really as ignorant as the medical correspondent of the *Times* makes us out to be, and if a considerable number of us really believed and acted upon the erroneous notions that Dr. Paterson calls "shibboleths," it would no doubt be well that we should be shown up. But as we are not and do not, it is unfortunate for our patients, that they should be led to believe that it is a thousand chances to one that their own particular doctor is wallowing in the abysmal ignorance of the *old* medicine or is treating them in accordance with principles from which all significance or meaning have disappeared. Dr. Paterson has sound and useful views on the treatment of patients in sanatoria and sets them out very clearly in his recently published book. His professional brethren are not so ignorant as he has been led to paint them by writing his book in a form to fit it to a taking title. It is generally wiser to write the book first and try to find a suitable title afterwards.

Immunity in Health. By Kenelm H. Digby, M.B., B.S., F.R.C.S. (Messrs. Henry Frowde and Hodder and Stoughton, London); price 8s. 6d. net.

The frequency with which the vermiform appendix and tonsils and adenoids call for surgical interference almost tempts us to regard them as troublesome links with our phylogenetic past. The author of this book, however, claims for these "poor relations," which he groups, together with the solitary follicles and Peyer's patches of the intestine, as the sub-epithelial lymph glands, the function of immunising the body against the commoner pathogenic organisms. After tracing the history of these glands in other mammals, he advances evidence that, in the case of the appendix at least, lymphocytes wander out into the lumen, and ,after infesting specimens of the prevailing flora, return to the lymphoid tissue to digest their prey, thus inoculating the body at a site of high resistance with a small dose of bacteria and their toxins. Although few new experiments are mentioned in the book, the author indicates the lines along which further work must be done in order to confirm his theory. While unable at present to accept *in toto* the author's view, we welcome this interesting and suggestive contribution by an old Guy's man to the well-known Oxford Medical Publications.

The Extra Pharmacopœia. By Martindale and Westcott (Messrs. H. K. Lewis & Co., Gower Street, W.C.) volume I., 17th edition; price 27s. net.

Five years have elapsed since the last edition of this standard work appeared, and, consequently, very extensive revision has been necessary in order to keep pace, on the chemist's side, with the various new methods of treatment discovered during the war years. While this book at present finds no place in the average medical library, in none other can the physician find, in reference to each drug, not only a summary of its pharmacological effects and therapeutic uses, but also records of published cases in which the drug has been administered, usefully or otherwise. To any man who considers that present day medicine does not represent the ultimate stage of advance—and we hope there are many such—this work is of supreme importance as an aid in directing therapeutic research. As a small criticism, the 1 per cent. alcoholic solution of picric acid has surely been sufficiently thoroughly tested at this Hospital to deserve a place among those antiseptics used for skin sterilisation prior to operations.

Cunningham's *Manual of Practical Anatomy.* Edited by Professor A. Robinson (Messrs. Henry Frowde) vol. iii.; price 12s. 6d. net.

With this volume, dealing with the "Head and Neck," the publication of the new edition of Cunningham is completed. We note many additional illustrations and dissections and improvements in the text, which will add to the value of this well-established work. We regret very much that the editor has insisted on retaining the Basle nomenclature. Whatever may be the state of affairs in Scottish Universities, the new nomenclature has found very little favour in London Medical Schools, and it appears to us very unfortunate that this opportunity was not taken to re-introduce the terminology in use in most schools and in the wards of all hospitals. Otherwise all the old features that have made this work so deservedly popular are retained, and "Cunningham" easily maintains its position as the best dissecting-room manual we have.

Manual of Surgery. By Rose and Carless (Messrs. Ballière, Tindall & Cox, London) 10th edition, 1920; price 30s. net.

The tenth edition of Rose and Carless' *Manual of Surgery* maintains the high standard of clearness and accuracy set by the previous editions. The war has left its mark on this book, as it has on everything else, and much new material directly due to the war has been added. Mr. Carless hopes in future editions to be able to dispense with a large

amount of this new material, but as long as we have war and the maimed from war it must be kept. Among the changes we notice that a description has been added of the methods of blood transfusion and the group relationships of donor and recipient. The section dealing with fractures has been enlarged, and many new and important illustrations have been added. There is a new chapter on Military Surgery, and a much enlarged one on anæsthesia. The X-ray plates in this edition are very beautiful and clear, but it is a pity that they have had to be relegated to the end of the book and could not be included among the letterpress which they are intended to illustrate. The completeness of this work (for it includes operative surgery) is sure to recommend it to all who are studying for examinations or who wish to have a handy work of reference.

Operative Surgery. By Alexis Thomson and Alexander Miles (Messrs. Henry Frowde and Hodder & Stoughton, Oxford Medical Publications) 3rd edition; price 16s.

When an author attempts to cover the whole field of operative surgery in the space of six hundred pages, it may be assumed that his object is not to give an account of the actual procedure and technical details of each operation. Herein lies the defect of the text-book under review, which gives an incomplete account of a very large number of operations, some of which, indeed, are rarely, if ever, performed. The essential of a manual on surgery is that it should be practical. If with its aid the student is able to carry out operations on the cadaver, then such a book must be declared to fulfil all requirements. If, on the other hand, it fails in this, then the value of such a work—apart from examination purposes—becomes problematical. It must be admitted that Thomson and Miles' *Operative Surgery* does give one a very good general idea of operative procedure, and will help the student to recall operations that he has actually seen performed in the theatre. Also the initial chapters on Transfusion, Artificial Limbs and Amputations are very interesting. For the rest, we must confess to a preference for the earlier editions of this well-known work, where the fewer operations set down are described in somewhat greater detail.

Dental Metallurgy. By Ernest A. Smith (Messrs. Churchill) 4th edition; price 12s. 6d. net.

This little book, which consists of about 250 pages, might be considered invaluable for students studying for the first professional L.D.S. Examination. It is not a metallurgical text-book—it does not profess to be—and anyone seeking for full descriptions of metallurgical processes would be advised to consult a larger work; but as a text-book which covers the syllabus of the First Professional Examination it is ideal. In the present edition the author has brought his work thoroughly up to date, and has re-written several sections. The chapter on Dental Amalgams—which is of special interest to all dental students—has been completely revised and much fresh data added; this was needed, as far too little is known of the behaviour of the various dental amalgams used as a filling material. We congratulate the author, and have no hesitation in recommending it to all students who are studying for the examination in Dental Metallurgy.

Notice.

Guy's Hospital Clubs' Union.

At a meeting of the Clubs' Union Council, held on September 7th, 1920, the following "Blues" and "Half Blues" recommended by the "Blues" Committee were approved by the Council:—

CRICKET.

Blues.—L. B. Helder, E. H. Muir-Smith, J. Van Schalkwijk, W. H. Willis.

Half Blues.—L. C. Willis, G. L. Shearer, J. D. S. Thomas, A. L. Mackay, J. C. Fauré, C. G. Bowen.

TENNIS.

Blues.—M. Jackson, L. Nurick, W. H. Cellier.

Half Blues.—E. E. Neser, B. J. M. Keyter, A. Daneel.

BOXING (Pavy Gym.).

Half Blues.—J. D. S. Thomas, S. P. Meacock, F. W. Stiven, R. F. H. Duncan.

SWIMMING.

Half Blues.—O. F. Painter, G. Cohen, R. Jarman, F. S. Hutchinson, R. Schofield, P. Harvey.

ATHLETICS.

Blues.—C. L. Steyn, J. Luke, L. G. Housden.

Half Blues.—A. S. Gough, R. R. Mackintosh, J. Harvey, R. S. Chambers, C. W. Greenway.

F. J. BIDDLE,
for Hon. Sec., Clubs' Union Council.

Cricket.

GUY'S v. BICKLEY PARK.

Played at Bickley on Saturday, September 3rd. On losing the toss Guy's took the field, and it was at once apparent that the bowlers were suffering from "holidayitis." Douglas and Chaplin, the Sussex captain, both batted, and hit finely. Bickley declared at 218 for the loss of only three wickets, leaving under two hours for Guy's to hit off 219. Vincent Brown and Fauré started well, and Schalkwijk and Hewetson carried on, the latter's innings being particularly bright and lasting about twelve minutes. Curle, owing to a fall while fielding, had to retire with a sprained wrist. When stumps were drawn at 7 o'clock Guy's were 171 for eight wickets. Scores:—

Bickley Park.

E. P. Solbie, c Vincent Brown b Taylor ...	19
C. K. Douglas, not out	67
H. Hancock, b Schalkwijk	7
H. P. Chaplin, b Hewetson	60
B. H. Tucker, not out	41
Extras	24
Total (for 3 wickets dec:) ...	218

Guy's.

C. Vincent Brown, b Chaplin	21
J. C. Fauré, c Chaplin b Douglas	36
A. L. McKay, b Tucker	0
L. B. Helder, c Sharp b Chaplin	0
J. Van Schalkwijk, c Chaplin b Douglas ...	41
J. C. Hewetson, c Sharp b Douglas	41
G. Curle, retired hurt	2
C. Helder, b Tucker	1
H. A. H. Harris, b Douglas	0
F. W. Taylor, not out	13
F. R. Payne, not out	2
Extras	14
Total (for 8 wickets)	171

Batting and Bowling Averages, 1920.

BATTING.

Name.	No. of Innings.	Times Not Out.	Runs.	Highest Score.	Average
G. D. Shaw	11	–	385	129	35·0
C. Vincent-Brown	6	–	199	100	33·3
T. Wooldridge	16	2	416	104*	29·7
E. H. Muir-Smith	15	–	402	105	26·8
J. Van Schalkwijk	20	1	380	92*	20·0
L. B. Helder	21	–	371	100	17·7
G. L. Shearer	19	4	237	55*	15·8
L. C. Willis	15	2	205	42*	15·7
F. R. Payne	7	6	15	8*	15·0
J. C. Fauré	8	2	85	36	14·2
J. C. Hewetson	16	1	190	42	12·7
T. J. Williams	11	1	91	21	9·1
R. F. H. Duncan	10	1	74	28*	8·2
W. H. Willis	9	–	66	21	7·3
H. A. H. Harris	6	–	38	25	6·3
F. J. Biddle	5	2	10	5	3·3
H. Slater	6	–	15	4	2·5
P. B. Skeels	7	2	6	3*	1·2
E. B. Corry	4	2		40*	28·5
V. R. Estment	3	2		6	14·0
G. Curle	2	1		9	11·0
J. D. S. Thomas	3	–		20	10·0
A. L. McKay	4	–		25	9·5
G. A. Milne	3	–		11	8·3

Nine others also batted once or twice.

*Denotes "not out."

BOWLING.

Name.	Overs.	Maidens.	Runs.	Wickets	Average.
T. I. Williams	29·6	5	95	10	9·5
J. C. Hewetson	48·5	6	199	15	13·3
T. Wooldridge	61·5	5	292	21	13·9
P. B. Skeels	91·5	21	276	19	14·5
J. Van Schalkwijk	291·4	46	1106	79	15·8
J. C. Fauré	77·5	16	256	12	21·3
F. R. Payne	59	11	239	9	23·2
F. J. Biddle	85	5	315	12	25·4
E. H. Muir-Smith	117·2	14	471	14	33·6

Eight others bowled under 15 overs.

Played 22. Won 7. Lost 9. Drawn 6.

Average per wicket 17.7
Opponents average ... ... 19·7

2ND ELEVEN.

BATTING.

Name.	No. of Innings.	No. of Runs.	Highest Score.	Times Not Out.	Average
A. L. Mackay ...	6	281	93	—	46·8
H. Slater	9	181	47	—	20·1
J. D. S. Thomas ...	8	154	46	2	19·25
R. G. Pengelly ...	8	149	63	—	18·6
H. A. H. Harris ...	6	104	40	—	17·3
R. F. H. Duncan ...	8	133	71	—	16·4
J. C. Fauré	5	48	34	2	16·0
T. M. Fripp ...	8	120	34	—	15·0
D. C. Eglington ...	6	72	32	1	14·4
F. R. Payne ...	5	70	23	—	14·0
C. G. Bowen ...	5	18	8*	2	6·0

BOWLING.

	Overs.	Maiden Overs.	Runs.	Wickets.	Average
C. G. Bowen ...	95	17	273	31	8·6
R. G. Pengelly ...	20	4	59	6	9·8
F. R. Payne ...	51	7	192	19	10·1
J. C. Fauré ...	65	12	215	20	10·75

Change of Address.

A. Wills, M.B., B.S., B.Sc., Friars Cottage, Princes Risborough, Bucks.

H. Shapiro, Grafton Hotel, Tottenham Court Road, W.

Lieut.-Colonel G. T. Birdwood, M.A., M.D., D.P.H., late I.M.S., 26, The Beach, Walmer, Kent.

Dr. Lauriston Shaw, 12, Park Square, N.W.1. (Tel. Mayfair 1480) *and* The Bungalow, Oatlands Chase, Weybridge (Tel. Weybridge 635).

Births.

NOOTT.—At Dumsey Deep, Shepperton, on September 10th, to Geoffrey and Hilda Noott, a daughter.

STALLMAN.—On September 6th, at 58, Thurlow Park Road, S.E.21, the wife of J. F. H. Stallman, M.B., B.S., of a daughter.

TEWFIK.—On August 28th, at 16, Kingswood Villas, Gillingham, Kent, the wife of I. Tewfik, M.R.C.S., L.R.C.P., of a son.

Marriage.

BIDDLE-SUTTON.—On 7th inst., at Southwark Cathedral, by Rev. R. French, M.C., Eric, elder son of Dr. and Mrs. Biddle, Merthyr Tydfil, to Rita, only daughter of Mr. and Mrs. A. Sutton.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

ACCORDING to tradition, this, the first issue of the GAZETTE in the new academic year, is the Annual Students' Number. It has been the custom of the GAZETTE for many years to bring out at this time of year a number which will appeal especially to the Freshman and which will give him some idea of the responsibilities he is undertaking both in entering the medical profession and in assuming his share of that great tradition which is the proud heritage of all Guy's men. To those new men whose privilege it is this month to commence their professional studies within the walls of Guy's, we offer a hearty welcome, congratulating them on their discrimination in their choice of a medical school and entrusting to them, with a confidence which past experience has amply justified, the honour and reputation of the Hospital.

The medical student who is starting his medical curriculum this year is embarking upon a ship sorely tossed upon the waves of reconstruction and reform. The storm still rages and the calm is not yet in sight. Every branch of medical education from the study of Chemistry and Botany to the arrangement of post-graduate courses is receiving attention from the critics, but so far little in the way of practical reform has been accomplished.

The fundamental defect with medical education at the present time is the tendency to encourage the study of science without reference to its direct connection with, and bearing upon clinical Medicine and Surgery. It is useless to expect the student to realise for himself that a considerable knowledge of Physics will be one of his most valuable assets when he starts his work in the wards. Yet this is so, and if there are any who are sceptical upon this point we would refer them to Sir Clifford Allbutt's remarks on another page of this number of the GAZETTE. The immediate importance of Anatomy and Physiology in Medicine and Surgery is more obvious, but even with these subjects better results would be obtained if the teachers and text-books dealt with them more from the clinical point of view. We believe that, at Guy's at any rate, something is being done in this direction. But much more extensive steps must be taken if medical education is to continue to provide the student with the very elaborate intellectual equipment which is becoming more and more necessary as our knowledge increases and our methods become more complicated.

It has always been the medical student's grievance that he is not brought into contact

with patients until a comparatively late period in his studies. The disproportion of what we may term the pre-clinical period to the clinical period of study is certainly surprising, and the necessity for it is not easily intelligible. At present the pre-clinical period occupies three years and the clinical period only two. During the pre-clinical period the student never sees a patient, except by accident or as the result of his own initiative. Considering that his life's work is to be devoted (except in a comparatively small number of cases) to clinical Medicine and Surgery it would appear reasonable that the clinical period of study should be at least equal to, if not actually longer than, the pre-clinical. In practice many men find themselves forced to extend the clinical period by six months or so because the two years allowed by the curriculum is not sufficient to enable them to reach the standard required for their final examination. It would be an easy matter for the authorities to lengthen the curriculum, but the expense of medical education is so great that such a course would be inadvisable unless it were found essential in order to maintain the high standard of education which the profession in England has attained.

We believe that a somewhat drastic revision of the curriculum will prove to be the only remedy for its present defects. We fully realise the supreme importance of much that is taught under the heading of "Preliminary Science," but we think there is a good deal that could be omitted without seriously impairing the mental equipment of the student. We should hesitate to recommend any extensive revision of the syllabus for Chemistry and Physics, but that for Biology might well be reduced by about half. But none of these things will be of the least use unless these subjects are taught (and learned), as Sir Clifford Allbutt says, "with faces turned to Physiology."

Equally important is it that Anatomy and Physiology should be taught with faces turned to clinical Medicine and Surgery. In order to introduce clinical interest into the work of the men engaged in the pre-clinical period of study, students from the Dissecting Room and Physiological Laboratory should spend at least two hours a week in the wards (and in "wards" we include the Out-Patient Department and Radiography Rooms). A step in the right direction has been taken at Guy's recently by the appointment of men still in the Dissecting Room as Dressers in the Fracture Department. But we should like to see regular attendance in the wards made a definite part of the last year at least of the pre-clinical period of study.

A much discussed feature of all branches of education is the compulsory lecture. Guy's students will find that there are here, as in nearly all Colleges, a number of lectures at which attendance is required by the regulations of the Medical School and Examining Bodies. Years ago when printing was a laborious and expensive process the lecture was one of the only means by which a man could learn to bring himself "mind to mind" with his teacher. Nowadays the abundance, excellence and comparative cheapness of the text-books and journals has altered the conditions of things entirely. Seven years ago a physician delivering a clinical lecture at Guy's complained that lecturers were unfavourably influenced by the knowledge that their lectures might be published and read by their colleagues and others for whose ears they were never intended. In the same way the advent of the daily press has deprived our politicians and statesmen of those great powers of rhetoric which distinguished men like Pitt, Fox and Burke. Nowadays politicians speak not to their audience, but, through the columns of the daily papers, to the Country.

There was at one time a Professor at Oxford who was in the habit of distributing printed copies of his lectures at the end of the term. There are still a few lecturers who merely dictate what they have to say and expect their students to make a verbatim report. Such methods are obviously futile, and fortunately they are not practised at Guy's. But the fact remains that the art of lecturing is a gift vouchsafed to comparatively few teachers. In so far as lectures are compulsory the student is compelled to take the good with the—shall we say—less good. Some men find lectures a genuine help. Others find that half an hour with their books is worth all the lectures in the world. We believe that attendance at lectures should be made an entirely voluntary matter, inasmuch as compulsory attendance is by no means the same thing as compulsory attention. Moreover, it can be no satisfaction to a lecturer to know that the well-filled theatre is due less to his own powers than to the stern necessity of his audience being "signed up." A Medical School should not cater for slackers. If lectures are useful, men will go to them. If they are not, they are merely a waste of time both to those who have to attend them and to the lecturers who have probably spent much time and thought upon their preparation.

Whatever method the student finds best for the purpose of acquiring knowledge he has no choice in the manner in which this knowledge is to be tested. From the beginning to the end of his hospital days examinations are a potent and unpleasant factor in his life. He is never free from them. He is like a man climbing a hill. He sees the summit not far above him. Optimistically he decides that his goal is nearly reached only to find when he gets there that another has taken its place. Perhaps his foot may slip, and he has to start afresh his weary ascent. When at last he arrives at the top and looks back upon the smaller peaks that he has surmounted and left behind his satisfaction is only equalled by his sympathy for those whom he can espy following the same slippery and tortuous path.

An old Guy's man, the father of a present member of the Staff, once observed that "examinations were an organised obstruction to systematic study." We think that a majority of men will agree with us when we say that this statement contains a great deal of truth. Examinations may be regarded as a necessary evil, but our quarrel is not with their existence so much as with the methods by which they are conducted. It is a common and consoling experience that men who work hard and prove their ability by deeds are not infrequently unsuccessful in their examinations. Conversely a number of men pass their examinations when subsequent experience proves them to be quite unfitted to undertake the duties for which their examination is supposed to qualify them. These are incontestable facts, and it is the comparative frequency of their occurrence which demonstrates the failure of our present examination system. The existing system has few merits. The temperament of the candidate is such an important factor that written papers and "vivas" may be no indication of a man's knowledge. They are certainly no indication of his industry. No system of examining will ever be a real success which takes no consideration of a man's general capacity and common sense apart from his book knowledge and technical skill. If space permitted we should like to discuss the question of examination reform in detail. We must be content, however, with suggesting that, as far as medical students are concerned, the candidate's work at the Hospital should be taken into consideration and definite marks allotted for his various Hospital appointments. Further, there should always be an internal

examiner amongst the examiners in any subject. We are aware of many difficulties in the way of such reform. But the essence of reform is the facing and removal of difficulties, and we believe that the deficiences of our present examination system are sufficiently great to demand immediate and fundamental alteration.

Elsewhere an announcement will be found of two demonstrations to be held at Lambeth Infirmary on "selected cases of types rarely seen in General Hospitals." This marks the beginning of an effort which is now being made to link up the Infirmaries with the Hospitals for teaching purposes. The Infirmaries contain vast quantities of clinical material of a kind that we hardly ever see in the wards of Guy's, and it will be of immense value to the senior student if frequent opportunities are given him of going round the wards of the Infirmaries.

An arrangement has been secured between Lambeth Infirmary and Guy's whereby certain infirmary cases will be admitted to the wards of the Hospital for investigation, and returned to the Infirmary when the investigations are completed. Such a system will ensure that a certain number of typical "Infirmary Cases" will, from time to time, be seen in our own wards, many of which will be chronic complaints which are unsuitable for ordinary admission to a General Hospital. We wish all success to the new scheme, and hope that the men in the wards will mark their approval by attending these demonstrations in large numbers.

We understand that the War Office is considering the question of restarting the R.A.M.C. Officers' Training Corps units which used to form the London Medical Schools' contribution to the London University O.T.C. Never a great success before the war, it will now be even more difficult to stimulate the requisite enthusiasm for this kind of work. But we think that it might be possible, if the function of an O.T.C. (implied by the name) is carefully borne in mind when arranging the work they are to carry out. The O.T.C.'s are intended to train men for Regular, Special Reserve, or Territorial Commissions. There is much that a R.A.M.C. officer must know which he will never learn in his hospital career. There is much that a R.A.M.C. officer does know which would be of immense value in civil practice. Army medical work is essentially the practice of Preventive Medicine, a branch of our art which is sadly neglected in our student days. If the hospital O.T.C.'s took upon themselves to train men in this sort of work they would be providing medical students who had decided ultimately to take a commission, whether regular or otherwise, with a most valuable training (which, incidentally, would greatly improve their chances of successfully entering one of the Services), and others, who had no military ambitions, with an insight into methods the use of which would enormously enhance their value as civilian practitioners.

Looking through past Students' Numbers of the Gazette, we find that it has been the custom of the Editor to offer words of advice and encouragement to the new men. We have chosen the easier and more congenial occupation of criticism, leaving the former task to three of the leaders of our profession whose contributions will be found in the following pages. We would only encroach upon the sphere of their activities to quote the following passage, concluding an address delivered, in 1892, at the University of Minnesota by the late Sir William Osler :—

"My message is chiefly to you, Students of Medicine, since with the ideals entertained

now your future is indissolubly bound. The choice lies open, the paths are plain before you. Always seek your own interests, make of a high and sacred calling a sordid business, regard your fellow-creatures as so many tools of trade, and, if your heart's desire is for riches, they may be yours; but you will have bartered away the birthright of a noble heritage, traduced the physician's well-deserved title of the Friend of Man, and falsified the best traditions of an ancient and honourable Guild. On the other hand, I have tried to indicate some of the ideals which you may reasonably cherish. No matter though they are paradoxical in comparison with the ordinary conditions in which you work; they will have, if encouraged, an ennobling influence, even if it be for you only to say with Rabbi Ben Ezra, 'what I aspired to be and was not, comforts me.' And though this course does not necessarily bring position or renown, consistently followed it will at any rate give to your youth an exhilarating zeal and a cheerfulness which will enable you to surmount all obstacles—to your maturity a serene judgment of men and things, and that broad charity without which all else is nought—to your old age that greatest of blessings, peace of mind, a realisation, maybe, of the prayer of Socrates for the beauty in the inward soul and for unity of the outer and the inner man; perhaps, of the promise of St. Bernard, '*pax sine crimine, pax sine turbine, pax sine rixa.*'"

The Cartoon which we are reproducing in this number of the Gazette was executed by Mr. Watson for the Job and Lydia Concert last Christmas.

Papers by Guy's Men.

A. L. Punch, M.B., M.R.C.S., "The Complement—fixation Test in Pulmonary Tuberculosis: Its use as a Means of Diagnosis."—*Lancet,* September 25th, 1920, p. 647.

The Profession of Medicine.

A new academic year begins on October 1st, and it is customary for the Gazette to indicate what is in store for those who have determined to follow the profession of medicine.

Those who wish for riches or those who desire an idle life should not become doctors. We look around and see business men living in expensive houses, and dying worth many hundreds of thousands of pounds, and lawyers making huge incomes, and several ex-Lord Chancellors all drawing pensions of £5,000 a year, but on the very rare occasions on which a doctor dies wealthy, his wealth has not been acquired in his profession, which offers no money prizes such as a business man may attain or comparable to that of a Lord Chancellorship, and many others open to lawyers. Nor is ours the calling for those who love idleness; the doctor mostly works very hard, frequent night calls, commonly plenty to do on Saturdays and Sundays, and generally speaking short holidays. Yet the writer heard a distinguished member of the Labour Party say that if he had been able to determine his own walk in life his first choice would have been that of a priest, his second that of a physician. He felt, and we agree with him, that these are two of the noblest occupations, for the reason that real success in them bears no relation to the money earned by them—indeed those who make most money are in truth usually the less successful—but is to be estimated by the good done. A doctor, who saves the life of a patient suffering from an illness, the treatment of which has required much skill and judgment, has his reward in his success irrespective of whether his patient is a pauper or a princess. The worker in the laboratory who discovers that malaria can be prevented by the extermination of mosquitoes, or that an army can be protected against typhoid by vaccination does not rush off to patent his process and demand royalties, he gives his results freely for the good of mankind and therein is his recompense. Indeed, the Royal College of Physicians prohibits those who belong to it from keeping secret any of the remedies they employ. The physiologist who adds to our knowledge of the working of the healthy body, the pathologist who unravels the problems of disease, the clinician who disentangles the symptoms and thereby discovers

which malady afflicts the patient, all play their part, which is not primarily to heap up riches, but above everything to render life more bearable for the sick and the maimed. Still, after all, a man usually becomes a doctor knowing he will have to earn his living by his profession. This he can always do, when he is qualified; the same cannot be said of some other occupations, and that of medicine has this supreme advantage, that those who are engaged in it and in its branches, whilst able to live by it, have a higher aim than money grubbing. Happily the object of a doctor rarely is, and never ought to be, to "cut prices," to undersell some professional neighbour. Many times it will fall to his lot to give his services for nothing, and the gratitude he receives often makes him happier than a cheque. All he looks for is that those who can afford to do so, pay him justly, and he rightly expects that he shall live to enjoy comfort without luxury and that it shall be possible for him to give his children a good education.

Thousands of doctors have in their lives received more presents from grateful patients than they can remember; this of itself demonstrates the common relationship between doctor and patient and how it differs from that between tradesman and customer. Another indication of the difference is that every right-minded member of the medical profession instinctively refrains from advertising himself to the public as though he sold soap; the very thought is abhorrent to him, and so intensely distasteful to all but a very small fraction of us that there are strict rules against it. In whatever branch of medicine a man is engaged it matters nothing what the public think of him, the true test is what do those of his brethren who know him and his work believe of him, their approbation is really the only thing for which it is worth while to strive.

In no department of medicine, be it practice of any sort or work in the laboratory, is there real drudgery, for the worker is constantly attempting to solve problems, no two of which are precisely alike, and in many instances he is also engaged in dealing with human beings in difficult and unusual situations; he may be tired, but he is never bored if he has chosen his profession rightly. All his life his occupation will be intellectual, never will he suffer the degradation of becoming a mere machine. His different faculties have to be exercised in turn, all are valuable to him. Sometimes memory will be his help, on other occasions imagination, reasoning power, dexterity, persuasiveness, or insight into character will be the means by which he attains his end.

We have tried to present the atmosphere in which after leaving the hospital students will follow their vocation; while here their work falls into two periods, that before they enter the wards and that during the time they are there. Soon after his arrival at Guy's the newcomer feels that he is part and parcel of a great institution with a long, lasting reputation for doing everything as thoroughly as lies in its power, and he quickly appreciates that there is stealing over him the consciousness that he is a fragment of Guy's and consequently whatever he undertakes must be performed as efficiently as he knows how, and with a zeal and enthusiasm which shall not tarnish but add—it may be only an infinitesimal mite—to the honour of the school to which he belongs. *Esprit de corps* is, as it ought to be, very strong here, and is entirely valuable, not only to Guy's as a whole, but to the individual, for it makes him put forth his best and become aware that all he does is partly for himself and partly for his hospital.

When the student reaches the wards he will discover that it is impossible to learn medicine from books alone. A text-book nearly always presents—it cannot do otherwise—a composite picture of a disease to which any individual case rarely conforms, but in the Out-Patient Department, the wards, the post-mortem room and museum you really do see the actual thing and the time spent in them cannot be too long. See and examine your patient, hear what your teacher has to say about him and then read some classic account of his disease.

It has been customary to consider that the opportunities for learning apart from that derived from books are at Guy's ample, and it is pleasant to see from Dr. Edward J. Wood's appreciative article in the Gazette for 21st of August last that this opinion is confirmed by a trained physician. Accustom yourself to observe and to reason from your observations, remember that X-ray, bacteriological and chemical examinations are only observations, and have to be taken in conjunction with others, and that very often you will in the course of your life have to form an opinion without these aids. Do not worry in your career at the Hospital as to what you will do when you leave;

it will depend largely upon the openings that present themselves at the time, and the choice is very large: if your bent is towards laboratory work you can become a physiologist, pathologist or bacteriologist; if you desire the feeling that your income is assured, and that a pension will ensue, you can enter one of the services, and in them, as is evident from the work done at Millbank, you are often given ample opportunities for keeping abreast of the times; if your inclination is towards any of the specialties you can follow it; if you desire an occupation that is chiefly administrative you can have it; if preventive medicine specially appeals you can get work in this branch; if you wish to teach you can seek a post at a medical school; if consulting work attracts you there are many opportunities in London and the Provinces; if you are fond of dealing with your fellow human beings there are practices in the country and in large towns. Whatever you choose you will almost certainly be happy; the discontented doctor is not common, and many doctors show in the best of all ways that they do not regret their lot, namely, by placing their children so that they shall follow their father's calling. Even when the sad time comes for you to start the stage that follows Guy's, do not be downcast, for, forty-three years ago (May, 1877) an old Guy's man writing in the GAZETTE said, "Much do I rejoice in being a Guy's man and in the thought that I shall never cease from being one," and Mr. Kidman, at the last Residents' going-off dinner, expressed the same sentiment, saying, "It was a sad moment when one came to leave Guy's; yet no one ever left Guy's completely."

W. HALE-WHITE.

Change of Address.

George Evans, M.B., The Mental Hospital, Brentwood.

A. G. Capel Davies, 8, Sussex Square, Brighton.

C. A. Ensor, from Tisbury, Wilts., to 9, Anerley Park, Anerley, S.E.20.

V. F. Soothill, 40, Dorchester Road, Weymouth.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

First Year's Studies in the Medical Curriculum.

By Sir CLIFFORD ALLBUTT, K.C.B., M.A., M.D., F.R.S.,
Regius Professor of Physic in the University of Cambridge.

THE Editor's call upon me to write a few words of welcome "to the new men in October" has followed me hither and thither on my holiday and now arrives at a moment when my words must be few and casual. The Guy's Hospital GAZETTE has from year to year been to me so useful a source of instruction and pleasure that I cannot decline the honour of becoming, however transitorily, a contributor to its columns.

I am to make some remarks to these new men upon the curriculum. These shall be, then, on their first year's studies—on physics and chemistry (biology I must set aside for the present). The impression among undergraduates has been, and I fear still may be, that these subjects—or physics more particularly—are tedious preliminaries set up by academic teachers, who cannot see that the modern young man wants "to get to business." That in truth—to use a familiar noun—they are "rot"—scholastic pedantry. Let us see.

We shall grant that when we set out for some point of vantage from which we are to have a wide and clear outlook, at first the walk from the plain may be tiresome; the view does not show itself. Nevertheless we cannot reach the view point without it. It is true that in his first, and perhaps second, year the purpose of these fundamental sciences is not obvious to the student. And teachers are beginning to see that the student's mistrust is not altogether unfounded; these sciences *have not been taught with faces turned to physiology*. It is all very well to say that sciences are to be taught disinterestedly, for their own sakes; the counsel is true and it is one we are in danger of forgetting, but it is a counsel of perfection. If a student is to be a "disinterested" physicist or a "disinterested" chemist, he may arrive at the goal of his curriculum when he has reached forty years of age. It seems sad that we cannot all have an ideal education; but the world and time are against us, not to mention the hard-pressed father.

Compromise we must; and the teachers of the ancillary sciences must accept the position

that their subjects are ancillary; but this relation does not for one instant lessen the intrinsic value and importance of them.

The rise of bio-chemistry is happily opening out even to the medical beginner the view of life as a transcendental kind of chemistry, so that I will not fill my small space with a sermon on chemistry: I will turn to physics rather. Biophysics is a star that as yet has hardly risen upon the medical student's horizon, but it is a great luminary and one that is to shed a large light upon our field of work. Now the teachers of physics, as I know from my happy experience at Cambridge, are not merely willing to teach physics from the biophysical point of view, but are actually doing it, and are keenly desirous to develop this feature of their work so as to integrate it with physiology, and so with clinical medicine.

Now this integration, or this orientation, is likely to be in two departments: the first will be a general groundwork of physics on practical lines — first year's work, or school work; and the second, a *revision of the physics* (as also of the chemistry, of course) in the light of later physiological experience (say at the end of the third year). At this stage the student will have grasped his own subjects fully enough to see vividly how widely and deeply such principles as surface action, osmosis, molecular tension and volumes, hydraulics, adsorption, catalysis, and so forth, are concerned in the *everyday practice of his profession*. These revision classes need not be long; granted the elementary knowledge, to point out the applications in physiology and pathology may be done occasionally in seminar work, but at present it is not done, or not done systematically; and the student enters upon clinical work, and even upon practice, regarding his early physics course as he regards his Greek grammar!

Furthermore, to come to my own teaching, for what it is worth; it is my custom for the Cambridge men who attend a few clinical classes, before leaving Cambridge for larger clinical fields, to bring before them cases, not of special pathology, but of physical and chemical interest, such as diabetes, the various dropsies, valvular diseases of the heart, certain renal diseases, and so forth. And, since the war, I have been able to obtain the help of one or other of our biochemical staff to join me in my clinical demonstrations. My colleague illustrates by the chemical reactions and principles what I am able to present to the class on the clinical and pathological side. Thus, the student begins to see (I hope) that he has been "getting to business" all the time! I may soon be enabled to take a like advantage of a biophysical colleague.

Here this brief message must end, but the reader will be able to add much more of the kind from obvious sources. To urge the essential need of physics in such direct relations as the application of X-rays, of the electro-cardiagram, of the properties of radium, of diathermics, of electro-therapeutics, and so on, requires no discussion. My concern for the moment is only with the claim of physical physiology.

On Learning Medicine.

By Sir ARCHIBALD GARROD, K.C.M.G., M.A., M.D., F.R.S.,

Regius Professor of Medicine in the University of Oxford.

The quaint old phrase "walking the hospital," once so commonly used by non-medical people, but now almost obsolete, had the merit of emphasising the principle which underlies the British system of medical education, that the student learns best by personal observation, and should, throughout his curriculum, be in close touch with the practical side of the subjects of his studies.

Far be it from me to discourage reading. Good text-books are essential; they systematise knowledge and help the student to fill the large gaps in his own experiences; and the advanced student should be encouraged to read monographs, which, of necessity, present a far more complete picture than any text-book can give.

Lectures, too, have their due place in medical education. The lecturer can emphasise essential facts, and can give a truer perspective of his subject than can cold print. Demonstrations in the laboratory, dissecting room, post-mortem room, or ward are of the utmost value as parts of the practical studies. The successful lecturer or demonstrator gives his own stamp to the subject of his discourse and expounds his own outlook derived from years

of experience. He needs to know far more of his subject than appears in his teaching, into which he weaves some part of that great mass of floating knowledge which constitutes the atmosphere of a school, a body of tradition handed down by generations of teachers. Most of us can recall some of his teachers at school, college or hospital who have specially influenced his mind, who have given him new outlooks, and have laid bare to him the very heart of a subject. Our debt to such men is never forgotten, they have helped to make us what we are.

A student can learn much by his own observation, and every man engaged in practice is so educating himself day by day, but without competent teachers and guides his progress would be slow. On the other hand, one who relies almost entirely upon what he reads and hears, and neglects to train and utilise his own powers of observation, can never become a competent medical man.

This, then, is a word of counsel which a senior in the profession, who has himself gone through the mill, and who, as all must do, looks back with regret to opportunities of which he failed to make the best use, can give to students at the outset of their career: *Utilise your senses to the full for the acquisition of knowledge, and above all train your eyes and ears and sense of touch.* This holds good from the day when the learner first enters the chemical, physical and biological laboratories to the day when he presents himself for his final examinations; and so to utilise his senses in his business throughout life.

Remember that the work of the medical man is the study of the abnormal, the recognition of its warnings, signs and symptoms, and the effort to preserve and, as far as possible, to restore the health of his patient. For any useful study of the abnormal it is necessary to have a thorough knowledge of the normal. Pathology is merely perverted physiology and morbid anatomy, and the essential bases of these sciences are chemistry, physics and biology. So each stage in a student's career is a necessary stepping stone to that which follows. If the preliminary subjects are neglected the foundations are badly laid and the whole structure raised upon them will be insecure. Do not let yourselves regard the earlier subjects as of less importance than the later ones, nor allow the natural impatience, which every student feels, to get into the wards, and to begin the study of what he looks upon as his life's work, to lead you to skimp those preliminary studies upon which the whole science and art of medicine rests.

Preliminary Address to New Dental Students.

(Reprinted from Gazette *of Oct. 18th, 1919.)*

By M. F. HOPSON.

Gentlemen,

My first duty, indeed my privilege, is to address a few words to the new men who are present. Speaking on behalf of my colleagues and the present students, I bid you a very hearty welcome. We are delighted to see you here in such large numbers, especially those of you who have come from over seas, and I can promise you all a very good time if you are prepared to play the game.

You have chosen of your own free will to seek and obtain the prerogative of calling yourselves Guy's men. What that signifies and stands for, all that it means, you will not fully realise until you have lived in the atmosphere of the old place for some considerable time, but if you are made of the right stuff it will soak into you gradually until finally you become saturated with it.

But I want you to seize hold of this right at the start, that you are first, and for all time, Guy's men, and the fact that you have entered as Dental Students is quite a secondary matter. Further, when a few days ago you signed the roll in the Medical School Office, you in a measure ceased to be absolutely free agents, for you incurred the responsibility of taking your share in maintaining the reputation and traditions of this great institution, and we are as jealous of the one as we are proud of the other. If you are not prepared to help us in this, you have made a great mistake in coming here, and I tell you frankly we have no earthly use for you.

In your clinical work do not forget that the treatment of the patient is just as important as the treatment of disease. You are no longer

working on a "phantom,' 'but dealing with a sentient, often hyper-sentient, human, who has just as much claim upon your skill and consideration as a private patient. Moreover, you are acting on behalf of a public institution and therefore open to public criticism; hence it behoves you to be punctilious in the discharge of any duties entrusted to you.

In all operative procedures, Be thorough, Be gentle, Be quick, may be taken as a sound working rule, and you may regard the relative importance of these qualities as being in the order stated. A thing which is well and properly done is done quickly enough.

Next, as to your school work. You have an immense amount of work to get through in a comparatively short period, far too short in my opinion, hence, method is everything, and "patience and tenacity of purpose are worth more than twice their weight of cleverness." Do not take everything you are told, or all you read, for granted; so far as you are able, put it to the test, and prove it for yourselves. Keep your eyes open and observe. Do not jump at conclusions; connote your observations, then think them over, and you may arrive at some new and interesting fact. Do not rely upon being spoon-fed by your teachers. Their business is to help you to learn. The motto of this Hospital is "Dare quam accipere"—It is more blessed to give than to receive—and on the flyleaf of every text-book you possess you might with advantage write this paraphrase: It is more blessed to learn than to be taught.

There is another thing I would warn you against, and that is working solely with your eyes glued on an examination. Huxley once said that "Examination, like fire, is a good servant, but a bad master." Do not let it become your master. Do not work merely to pass; work to know. There are unfortunately many who pass and who do not know.

Whilst you are here you will have the opportunities of laying down a foundation on which to build knowledge, such as may never occur again. Seize them and remember that true culture is but the sediment of things we have forgotten.

You have to be learners all your life, and the best student is he who, when he has passed his qualifying examination, is most conscious of the fact that he must be a learner still.

Correspondence.

To the Editor of Guy's Hospital Gazette.

"The Selection of the Anæsthetic."

Sir,—In your last issue Dr. Aston Key asks my opinion of the value of atropine before nasal operations. I think it is of especial value in this class of case for the reasons which he has himself given, and also because it helps to lessen after-vomiting by diminishing salivation and secretion of mucus. I may add that it is the custom at Guy's to give atropine in doses ranging from 1/200 gr. to 1/100 gr. to all patients before operation, whatever the nature of this may be.—Yours, etc.,

FRANCIS E SHIPWAY.

61, Queen Anne Street, W.

"Rugby Football Reminiscences."

Dear Sir,—In my letter in your last issue with some sporting reminiscences, there was one point which I omitted to emphasise, and should like to do so now, viz., that our present senior physician, Dr. John Fawcett, shared with Sir Alfred Fripp in being two of our best forwards in the 1887-88 Rugby team.

It almost makes one regret not having got on the Staff to sit under such a pair of good sportsmen as Guy's now has at head of things.—Yours faithfully,

A. ALLPORT.

9, Charles Street,
St. James's Square, S.W.1.
September 23rd, 1920.

"The Chaplain's Department."

Dear Sir,—I would be most grateful if I might be allowed space to bring to notice these things:—

1. I am hoping to arrange during the coming winter months some lectures for students of a religious nature by some notable people. When this materialises I will advertise the fact. Such lectures were given last year, and were appreciated, so I hope if they can be arranged again many will come to the lectures.

2. The Students' Christian Movement has a very small branch in this Hospital. Perhaps little is known of the Movement, so it is hoped to call a meeting soon in order to make the objects of the Movement known. Mr. Charles Gallagher is the honorary secretary, and will be very pleased to give any information he can on the subject.

3. Some years ago we used to get several students in the choir at 7 o'clock evensong Sunday nights in the Hospital Chapel. Cannot this be done again? Such help would be really welcome. It

is a great thing for a student to enter in wholeheartedly in all that concerns the life of the Hospital, so I want to put in this plea for our Chapel.

Finally, let me say there are many reasons that make it difficult for a Chaplain to get on terms of friendly relationship with the students. Let me say this. I do desire this friendship. I have a room in the Hospital next to the Chapel, and it will always be a pleasure to see any who will come along and see me there.—Yours faithfully,

H. J. HAWKINS.
(Chaplain).

Guy's Hospital,
London, S.E.1.
September 28th, 1920.

"Ave."

Dear Mr. Editor,—May I be allowed, through the Gazette, to wish all those remaining who fifty years ago entered Guy's with me, all hearty good wishes and congratulations. Time brings many changes, but pleasant memories will ever remain.—Yours faithfully,

WM. E. DRING.

"Elmstead,"
Tenterden, Kent.
October 1st, 1920.

Clinical Lectures.

Dear Sir,—Can anything be done through the medium of your lines to remedy the plight of ward men attached to surgical or medical firms in view of their difficulty in attending Clinical Lectures.

These lectures are held between the hours 1.30 and 2.30 p.m. on Mondays and Wednesdays, whereas the ward man has to associate himself with his firm at 2 p.m. on Mondays, thus making it impossible for him to attend the lectures on these days.—Yours obediently,

DRESSER TO SURGICAL UNIT.

Guy's Hospital Clubs' Union.

The formation of the Clubs' Union, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Year Book) to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of the constituent institutions.

The past year has seen a great reconstruction of the Clubs' Union. It has recovered from the effects of the war quicker and better than that of any other hospital, and has, if anything, already surpassed its excellent pre-war standard, as may be seen by the splendid collection of Cups in the Smoking Room.

The Union comprises the following Constituent Institutions:—Association Football Club, Athletic Club, Boat Club, Cricket Club, Debating Society, Dental Society, Gazette, Golf Society, Hockey Club, Lawn Tennis Club, Pavy Gymnasium, Physical Society, Rifle Association, Rugby Football Club, Students' Club, and Swimming Club.

On joining the Union a student is entitled to take part in the activities of any of the above Constituent Institutions. The ground of the Clubs' Union, which is under the control of the Council, is situated close to Honor Oak Park Station on the London Brighton and South Coast Railway, and to Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. A Fives Court, under the management of the Students' Club, is situated behind the Nurses' Home near the Swimming Bath, and arrangements are made for classes in boxing and gymnastics in the Pavy Gymnasium. The Boat Club, which was revived during the summer, and which celebrated its revival by bringing the Hospital Cup to Guy's for the first time in its history, is affiliated to the London Rowing Club at Putney, and members are entitled to all the advantages of that Club. Meetings of the Debating, Dental and Physical Societies are held from time to time in the College.

The membership subscription of the Union has recently been raised to five guineas. In spite of the large increase in the number of members a rise in the subscription rate (perhaps only a temporary one) was necessitated by the rise in the cost of labour and material.

Extensive alterations have been carried out in the Students' Club to provide greater accommodation and comfort for the members, and are dealt with in a separate paragraph on the Students' Club.

At Honor Oak Park two additional stands have already been erected to hold 100 each, and during the coming year it is hoped to move and enlarge the old stand so that the seating accommodation will be increased to at least 1,000. The pavilion also will be put into the builder's hands when necessary alterations will take place.

As any student can see, these alterations in themselves necessitate an increase in the membership subscription. The Utopian ideal of a new Students' Club may even yet be realised in the future, thus adding another burden to the finances of the Union.

Membership cards are now being issued entitling the holders to the privileges of membership of each of the Constituent Institutions.

New members should consult the notice-boards in the Colonnade for information as to the activities of the various Clubs.

An excellent programme of home matches has been arranged by the Rugby Football Club (*vide* Fixture Cards), and it should be noted that free admission to the ground during matches at Honor Oak Park is granted only to members of the Union on production of their membership cards.

Students' Club.

The premises of the Club include the Smoking and Reading Rooms and the Dining Hall, in the College.

All three rooms have recently been redecorated, and, in addition, alterations have been carried out in the Dining Hall and the Smoking Room. It is hoped in this way not only to increase the accommodation but also to expedite the service during meal times.

In the Reading Room the periodical cases have been renovated and the paper stands have been brought up from the Smoking Room, where they used to be in a state of decay.

A good supply of papers and periodicals is now maintained, and it is hoped that all members of the Club will assist the Committee by themselves seeing that the periodicals, etc., are kept in good order. The taking of periodicals out of these cases or the removal of papers from the Reading Room throws a lot of extra work on to the Librarian, and members ought not to expect the Committee to keep up a constant supply of papers if these are continually removed as soon as they are placed in the Reading Room.

The Library in the Reading Room has also been thoroughly rearranged. A new catalogue has been made, and can be inspected at any time.

Notices are posted in the Reading Room stating the regulations of the Library, and students should avail themselves of this opportunity of a good supply of general literature which for once has no connection whatever with medicine.

Through the Library books may also be obtained from Mudie's Library.

At a meeting of the Clubs' Union Council held on September 7th, the following officers were elected:

President.—Sir W. Hale-White, K.B.E., M.D.

Chairman.—R. P. Rowlands, O.B.E., M.S.

Committee.—F. J. Steward, M.S.; J. A. Ryle, M.D.; T. B. Johnston, M.B., Ch.B.; W. K. Fry, M.C., L.D.S.; W. H. Cellier; M. Maizels; H. G. R. Canning; R. F. H. Duncan.

Treasurer.—G. H. Hunt, M.D.

Secretary.—W. D. Doherty.

Assistant Secretary.—C. H. C. Toussaint.

Auditors of Constituent Institution Accounts.—M. Maizels and C. H. C. Toussaint.

The attention of all members is drawn to Rule 20 of the Clubs' Union:—

"Every member whose subscription is more than one month in arrear shall be suspended from the privileges of membership, and his name shall be posted in the Students' Club. After two months' default he shall cease to be a member of the Union, and shall not be re-admitted without the consent of the Council, who shall, if they think fit, impose a fine of five shillings upon his re-admission."

A list will shortly be posted in the Students' Club of members who have failed to comply with the rules, and the Secretaries of Constituent Institutions will be notified that the members named are not entitled to the privileges of the Union until their subscriptions have been paid.

W. D. DOHERTY.
Hon. Sec., Clubs' Union.

University of London Club.

The University of London Club, which was established in 1914, occupies premises at Nos. 19, 21 and 23, Gower Street, near Bedford Square and the British Museum. Mainly owing to circumstances arising from the War, the loss of members from death, resignation, and other causes, has during the six years of the Club's existence exceeded the number of new members by an average of twenty *per annum*. With a view to restoring the original membership of the Club, the Committee have decided to suspend payment of the entrance fee of two guineas in the case of candidates whose applications are in their hands on or before the 31st December, 1920. The annual subscription for ordinary members elected after August 1st, 1919, is three guineas for town members and two guineas for country members. Graduates, teachers, and officers of the University and persons, other than students, connected with its Colleges, Schools, Institutions and Organisations are eligible for ordinary membership. Meetings of recognised University Societies, including the Students' Representative Council and the Musical Society, are held in the Conference Hall of the Club, which is also used for official purposes connected with the University. The neighbouring houses, Nos. 13, 15, 17, 23 and 25, Gower Street, have been leased by an independent company entitled "Club Chambers, Limited" with a view to providing residential accommodation for Club members and their friends.

Come all you gay young fellows,
Take notice as you go,
And come next Saturday to see
Our Frank and Joey Show.

Now Joey is an artful Bird,
For all his hanky-panky,
But if you'll take a tip from me,
You'll put your bob on Franky.

Reviews.

Surgery. A text book by various Authors. Edited by George E. Gask, C.M.G., D.S.O., F.R.C.S., and Harold W. Wilson, M.S., M.B., F.R.C.S. (Messrs. J. & A. Churchill); price £2 2s.

Certain rather obvious pot-boilers having quite recently been foisted on the aspiring surgeon, it is with a critical eye and a determination to remain unbiassed, even by the hall-mark of Bart.'s and the setting of Churchill, that we review a further volume. Without making any considerable claims to originality, this work will fully justify its existence. The serious production of a surgical text-book is a task demanding, *inter alia*, courage and an ability to compromise. The fascination of surgery is found essentially in practice; book surgery, as generally understood, is a comparatively uninteresting subject, whilst its scope and limitations are difficult of definition. The fundamental attributes of a surgeon are a knowledge of anatomy, physiology and pathology, together with judgment and technical skill. A good surgeon is characterised by that "sixth sense," really a product of common sense and experience, which enables him rapidly and almost subconsciously to apprehend and balance alternative possibilities. A brilliant surgeon is distinguished by imagination and originality of application. Some regard surgery as a branch of science, others as a craft pure and simple; yet it is perhaps as an artist that the surgeon reaches his highest degree of development.

Wherein, then, lies the function of a surgical treatise? Excellence, common sense, and dexterity cannot be conveyed on paper. Anatomy physiology and pathology, the corner stones of surgery, are worthy of far greater respect than is signified by the traditional concession of the first hundred pages or so of every typical text-book to the subject of "surgical pathology," whatever that may be. There is, however, a fairly definite and commendable object to be attained in imparting the fruits of clinical experience to the comparative beginner. As this has been the express aim of the editors of the new volume, it is a little disappointing to find that they have not made a bold sweep to the exclusion of those inevitable preliminary chapters on inflammation, the preparation of surgeons and nurses, etc. This may be a small matter; but it is a question of principle: so great is our respect for inflammation, surgeons, and nurses, that we resent seeing them summarily dismissed in a few pages. Of course, we must never forget the dominating and evil influence of the examination hall; no editor can afford to lose sight of Lincoln's Inn Fields.

Lest we should appear to belittle the individual efforts of the author to whom has been entrusted the unenviable task of dealing with these general topics in a limited space, let us hasten to reassure him. His contribution is an admirable precis, though stereotyped and somewhat behind the times. More fashionable subjects, such as Shock, have been treated all too briefly.

On the whole the text is distinctly good, and the editors have made their mark. More than ever are we impressed with the value of collaboration and team work. Many of the sections have been written by masters of their subjects, and a high standard has been maintained throughout. We do not look for inspiring passages in a text-book, but we do at least expect accuracy and a certain degree of completion. The attitude of any one man who sets out to write a tome on modern surgery from A to Z can only be surmised. If he fondly imagines that he is conferring a benefit on humanity he must be a fool of the most pernicious type. But let each writer deal only with that part of the subject which happens to be of interest to himself, and he will interest his readers. Provided the editors carefully choose their authors and insist on a due regard for accuracy and proportion, the success of the work is guaranteed.

We have been compelled to admit that this is a really excellent book of its kind. It is to be recommended as a sound investment for the undergraduate, for the post-graduate who is revising his more elementary knowledge preparatory to one of the higher examinations in surgery, and for the general practitioner who needs a book of reference. Although some of the coloured plates are more beautiful than lifelike, the black and white illustrations and the printing are excellent.

The X-Ray Atlas of the Systemic Arteries of the Body. By H. C. Orrin, O.B.E., F.R.C.S.Ed. (Messrs. Baillière, Tindall & Cox, London, 1920) pp. viii. plus 92, plates 21; demy quarto.

In this work the author has restricted the letter-press to a minimum, and attention is naturally directed to the plates. For the most part these are reproductions of X-ray photographs of the injected vascular system of a full-time human fœtus. These photographs are admirable, and are excellently reproduced.

As a means of studying the inter-connections of the various arteries, this method of X-ray demonstration has much to recommend it, but the fact that no photographs are given of individual arteries lessens the value of the work. In no case should it be presented to the medical student before he has completed his dissections, and grave doubts may be expressed as to whether the work is likely to be of practical value to anyone except the general surgeon. Owing to the frequent overlapping and crossing of the various vessels, the identification of the individual arteries in some of the plates presents considerable difficulty, and can only be satisfactorily determined after consulting the stereoscopic plates, which are included in Plates XX. and XXI. Thus the artery indicated as the *middle colic* in Plate XIII. proves to be one of the *rami intestini tenuis*, when the stereoscopic photograph on Plate XX. is examined, the *middle colic* being partially obscured by the *right renal artery*.

The author suggests that his method displays the exact relationships of arteries to bones, but, unless the observer is provided with a stereoscopic picture and knows the positions of the plate and the tube relative to the body, the ideas of such relationships cannot be so nearly exact as the ideas obtained from an ordinary dissection.

T.B.J.

Public Health Laboratory Work (Chemistry). By H. R. Kenwood, C.M.G., M.B. (Messrs. H. K. Lewis & Co.) 7th edition; price 15s.

The aim of this book is to describe the best method of performing a given analysis and having done so to explain the results clearly; superfluous methods which cumber so many text books and perplex most students are omitted. The book is divided into six parts, with an introduction dealing with the general technique of laboratory work.

Part I. deals with water analysis and is excellent; Part II. on Sewage is brief but to the point, as also is Part III. on Soils.

In Part IV. on Air Analysis while the methods and general findings are clear enough one misses the critical survey of analysis with reference to the practical value of the figures obtained.

Part V. on Food Examination is good, but it would be still better if the average analysis and recognised standards were placed together at the end of each chapter instead of being mixed up in the text. The 6th Part on the examination of Disinfectants is disappointing.

Notices.

Two Special Demonstrations in selected cases, of types rarely seen in General Hospitals, will be given at the Lambeth Infirmary on Tuesday, October 19th, and Tuesday, December 7th, at 5 p.m. These demonstrations are open to all students who have passed the Second Examination in Anatomy and Physiology.

T. B. JOHNSTON,
Dean.

One of the most interesting and we believe biggest deals in the X-ray trade that has ever been arranged in this country has just been concluded by X-Rays Limited, which has purchased the whole of the X-ray and Electro-Medical business of the High Tension Company, including the plant, stock, goodwill, and many valuable patents.

Mr. Mortimer A. Codd, who is well known in connection with his work on High Tension Apparatus during the war and his authorship of a standard work of reference in connection with these instruments, will in future disassociate himself entirely from business and has entered into an agreement with X-Rays Limited as director of research. This places his unique laboratory at their services, and should have immense and far-reaching results in the designs of the X-ray apparatus in the near future.

St. Marylebone General Dispensary.

77, WELBECK STREET, CAVENDISH SQ., W.1.

Telephone: Mayfair 3260. Tube Stations: Bond Street or Oxford Circus.

POST-GRADUATE COURSE ON INFANT AND CHILD WELFARE.

A Course of Twelve Practical Demonstrations on the Management and Feeding of Infants and Young Children will be give by Dr. Eric Pritchard (Physician in charge of the Infant Welfare Department) to Qualified Practitioners, commencing Tuesday, October 5th, 1920. The Demonstration will be given on Tuesdays and Thursdays at the St. Marylebone General Dispensary.

Tuesday, October 5th, at 10.30 a.m., "Causes of Infant Mortality."

Thursday, October 7th, at 3 p.m., "How to establish an Infant Welfare Centre and conduct an Infant Consultation."

Tuesday, October 12th, at 10.30 a.m., "How to Examine an Infant and keep Records."

Thursday, October 14th, at 3 p.m., "Breast Feeding."

Tuesday, October 19th, at 10.30 a.m., "The Artificial Feeding of Infants."

Thursday, October 21st, at 3 p.m., "The Modification of Milk."

Tuesday, October 26th, at 10.30 a.m., "The Uses of Dried Milk and Patent Foods."

Thursday, October 28th, at 3 p.m., "The Management of Difficult Cases."

Tuesday, November 2nd, at 10.30 a.m., "Treatment of Minor Ailments."

Thursday, November 4th, at 3 p.m., "The Training of the Motor Functions of the Digestive System."

Tuesday, November 9th, at 10.30 a.m., "The Treatment of the Heat Regulating Functions."

Thursday, November 11th, at 3 p.m., "The Feeding of Children between 9 months and 2 years."

Opportunities will be afforded to Students attending this Course of visiting the Nursery Training School, 1, Wellgarth Road, Golder's Green (5 minutes from Tube station), and seeing the methods there employed in dealing with infants. The visits will be paid on Saturday afternoons.

Ticket for the Course: Two Guineas.

For further information, tickets, etc., apply to the Secretary, 77, Welbeck Street, Cavendish Square, W.1.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

October Class, 1920.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals on the days and at the times stated below.

N.B.—Attendances may be commenced during the second month of a course, but certificates in respect of that course will only be granted to students who join not later than the end of the first month.

Eastern Hospital, Homerton Grove, Homerton, E.9. J. Wilkins, M.R.C.S., Medical Superintendent. Monday and Thursday at 11 a.m., beginning 7th October.

North-Eastern Hospital, St. Ann's Road, Tottenham, N.15. F. H. Thomson, M.B., Medical Superintendent. Monday and Thursday at 11 a.m., beginning 4th October.

North-Western Hospital, Lawn Road, Hampstead, N.W.3. E. W. Goodall, M.D., Medical Superintendent. Tuesday and Thursday at 2 p.m., beginning 5th October.

Western Hospital, Seagrave Road, Fulham, S.W.6. R. M. Brûce, M.R.C.S., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 5th October.

South-Western Hospital, Landor Road, Stockwell, S.W.9. F. Foord Caiger, M.D., F.R.C.P., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 5th October.

Park Hospital, Hither Green, Lewisham, S.E.13. T. H. Woodfield, M.D., D.P.H., Medical Superintendent. Tuesday and Friday at 2.15 p.m., beginning 5th October. (Train from Charing Cross 1.50 p.m., and London Bridge 1.58 p.m. to Hither Green).

Brook Hospital, Shooters Hill, Woolwich, S.E.18. J. B. Byles, M.B., Medical Superintendent. Monday and Thursday at 2.30 p.m., beginning 4th October. (Motor Omnibuses from Blackheath Station (South Eastern and Chatham Railway) to the Hospital).

The succeeding Course will commence in January, 1921.

Students who desire to attend a Course of Instruction must, *before* attending at the Hospital, bring between 11 a.m. and 4 p.m. on any week-day (except Saturday) or send by post to The Clerk to the Metropolitan Asylums Board, Embankment, E.C.4.—

(1) Authority from the Dean of the Medical School.

(2) Fee, £3 3s. for 2 months' course or £4 4s. for 3 months' course, cheques to be made payable to "The Metropolitan Asylums Board."

The Student must definitely ascertain *before* taking out his course whether he requires a 2 or 3 months' course. In the event of his taking out a three months' course, the extra £1 1s. will not be refunded to him.

(3) Full name, address, and name of Medical School (N.B.—The name must be in full and must be distinctly written).

(4) The Names of at least two of the above Hospitals, arranged in the order in which the Student would prefer to attend, in case the classes at any of the Hospitals should be already full.

By order,
DUNCOMBE MANN,
Clerk to the Board.

Lawn Tennis.

The Lawn Tennis season at the Hospital culminated on Tuesday, 20th July, when we played Bart.'s in the final of the Senior Inter-Hospital Cup. This year we were again unsuccessful, and Bart.'s won a decisive victory by 9 matches to 3, 3 being left unplayed. It is interesting to note that the only matches we won were those in which M. Jackson took part.

The scores for this match and the fixture list with results to date are appended.

Guy's v. Bart.'s at Roehampton.

Singles:—M. Jackson beat R. F. Johnstone, 6—1, 6—3; L. Nurick lost to C. F. Roupell, 1—6, 6—3, 4—6; W. H. Cellier lost to R. R. Powell, 2—6, 4—6; B. L. Laver lost to W. D. Urwick, 5—7, 2—6; B. J. M. Keyter lost to J. G. Johnstone, 5—7, 4—6; J. W. Schollum lost to W. E. Cody, 6—3, 4—6, 5—7.

M. Jackson and L. Nurick beat J. G. Johnstone and R. R. Powell, 6—3, 7—5; beat R. F. Johnstone and W. D. Urwick, 6—2, 4—6, 7—5.

W. H. Cellier and A. Daneel lost to R. F. Johnstone and W. D. Urwick, 4—6, 2—6; lost to P. Smuts and C. F. Roupell, 6—8, 4—6.

B. J. M. Keyter and E. E. Neser lost to J. G. Johnstone and R. R. Powell, 8—10, 0—6; lost to C. F. Roupell and P. Smuts, 3—6, 8—6, 4—6.

In the Junior Cup we were beaten by King's First Six in the Semi-Final.

CLUB MATCHES.

May	11th	v. Cambridge University	Away	L	1—8.
"	15th	v. Univ. Coll. Hosp.	Away	W	7—2.
"	19th	v. Oxford University	Away	L	3—6.
"	22nd	v. Wallington	Home	W	9—0.
"	26th	v. Univ. Coll. Hosp.	Home	W	6—3.
June	2nd	v. Sutton	Away	L	3—6.
"	5th	v. Redhill	Home	W	6—3.
"	6th	v. Gallery	Home	W	5—4.
"	19th	v. Kew	Home	L	2—6.
"	20th	v. Dulwich	Away	W	5—4.
"	23rd	v. Lowther	Away	W	9—0.
"	26th	v. L.C.W. & Parr's Bank	Home	W	6—3.
July	3rd	v. Epsom	Away	L	2—7.
"	4th	v. Roehampton	Away	L	1—8.
"	14th	v. Lowther	Home	W	9—0.
"	18th	v. Gallery	Away	W	5—4.
"	24th	v. Epsom	Home	W	6—3.
"	25th	v. Purley Bury	Away	L	3—5.
"	31st	v. Grafton	Home	L	3—6.
Aug.	1st	v. Dulwich	Home	W	9—0.
"	7th	v. Hill	Away		——
"	14th	v. Sutton	Home		——
"	21st	v. Kew	Away		——
Sept.	4th	v. Wallington	Away	W	8—1.
"	11th	v. L.C.W. & Parr's Bank	Away	W	5—4.

Draw for the Lane-Washburn Cup.

LAST FOUR ROUNDS.

Fourth.	Fifth.	Semi-Final.	Final.
J. Schollum M. Jackson	M. Jackson	M. Jackson	M. Jackson 6–3, 2–6, 6–2
Shearar B.J.M.Keyter	Shearar		
B. L. Laver R. Macintosh	B. L. Laver	L. Nurick	
L. Nurick E. E. Neser	L. Nurick		

Specialities.

Messrs. P. K. ARM, Ltd., 1, Clarence Street West, Belfast.

Manufacturers of artificial limbs have produced many substitutes for hands and arms, but most of these have been, until lately, more or less ornamental in character, and of little real service to the wearer.

The P. K. Mechanical Hand and Arm, however, is a distinctly serviceable device, far ahead of any other similar appliance, and its value has been justly and widely acknowledged.

Under the authority of the Ministry of Pensions hundreds of ex-soldiers have been fitted with the P. K. Mechanical Hand and Arm, and they are now able to earn their living at their own trades as before the war.

The P. K. Hand and Arm is the invention, after two years' careful preparation, of Mr. A. Pringle and Surgeon T. S. Kirk—the former a skilled tool designer and the latter a practical Belfast surgeon—who have followed as nearly as possible the anatomy of the human hand, and in so doing have achieved success of which they may be justly proud.

Space unfortunately prevents us from describing in detail the mechanical working of this contrivance, but as Messrs. Pringle and Kirk are exhibiting at the forthcoming Medical Exhibition, we hope that all those who visit this exhibition will make a point of seeing for themselves this very clever contrivance, and the wonderful work it can do.

Football.

CATFORD BRIDGE v. GUY'S HOSPITAL.

With this fixture the Rugby ball was started rolling again for another season, and all hope it will be as successful as the last. The Fixture List is a stronger one, but nothing like so formidable as our strength of last year should have guaranteed us. On looking through the list one notices an awful scarcity of home fixtures for First XV. between November and February. One hopes for the sake of our home supporters this will not occur again. People who follow our fortunes regularly should hardly be left two months without a home match. Small wonder if our crowd, if one may use the expression, adopt some other favourite.

A first match is always a trying one for the players, and as the afternoon of September 25th was particularly humid only 2×30's were played. Our team were on top at once, and the form shown was distinctly promising, the backs passing with great accuracy and precision. Catford did not prove very enterprising in attack, but in defence their rear guard did all and more than could be expected. The full-back, T. D. Bartlett, tackled manfully throughout, and J. H. Batty played a determined game, but there was not much pace opposed to us, so that once our attack was on the move they got through with ease. Watson got the first try, Van Schalkwijk kicking a good goal. Then Steyn got a couple, and one was converted. Graham Davies was inches out only on a couple of occasions, and Van der Post, who showed that his hands were as good as his feet, accepted a long pass from Macintosh and ran in wide out. Van Schalkwijk converted one again, half-time finding us 16 points to the good.

The second half opened with Steyn in the centre and Graham Davies on the wing. All very well against a weak side for an experiment, but Graham Davies is too good a centre for anybody to take his place. As straight a runner and as stout-hearted a defender as ever donned our jersey. One cannot imagine a player who, in this position, would think so much of going on the wing. Graham Davies got two tries this second half. Bekker got two, more or less subterranean. Watson and Van der Post scored another one apiece, and last but not least came a good try from Krige. Olivier had nothing to do; Macintosh and Taylor shaped well. They will be very useful men. Shelswell proved himself as good as ever, and Biddle was about the best forward playing. Watson proved himself a good opportunist, his pace is a valuable asset to any side. Van Schalkwijk converted once, the final scoring being Guy's 3 goals 8 tries, Catford nil. The only really noticeable thing about the second half was the extremely accurate passing, the ball being seldom if every missed, and the lightning run of Steyn's which Graham Davies followed so cleverly to receive an inside pass and score his last try behind the posts. Guy's team:—

W. Olivier, C. L. Steyn, H. Graham Davies, J. A. Krige, C. Van der Post, F. Bekker, J. Van Schalkwijk, W. D. Doherty, A. H. Shelswell, R. F. H. Duncan, F. Biddle, L. K. Watson, A. H. Van Zijl, W. H. Taylor, and R. R. Macintosh.

Fixtures, 1920—21.

RUGBY.

First Fifteen.

1920.		
Sep. 25	Catford Bridge	Away
Oct. 2	Blackheath	Home
9	London Irish	Home
16	Gloucester	Away
23	Harlequins	Home

27	Oxford University	Away
30	Rosslyn Park	Away
Nov. 6	United Services	Away
13	Northampton	Away
17	Cambridge University	Home
20	Rosslyn Park	Home
27	Old Blues	Home
Dec. 11	London Welsh	Away
15	Cardiff	Away
18	Old Millhillians	Away
1921.		
Jan. 8	London Scottish	Away
15	United Services	Home
19	Cambridge University	Away
22	H.A.C.	Away
29	Catford Bridge	Home
Feb. 5	London Welsh	Home
12	Old Alleynians	Home
19	Gloucester	Home
26	Old Leysians	Home
Mar. 12	Leicester	Away
19	Richmond	Away
26	Old Blues	Away
Apr. 2	Coventry	Away

SECOND FIFTEEN.

1920.		
Oct. 2	Southend	Away
9	Old Elthamians	Home
16	Old Alleynians	Home
23	Harlequins "A"	Away
27	R.A.S.C.	Home
Nov. 6	Old Blues "A"	Home
10	Downing College	Home
13	London School of Economics ...	Home
17	R.A.F. Uxbridge	Away
20	Royal School of Mines	Away
24	R.A.S.C. Aldershot	Home
Dec. 1	R.N.C. Greenwich	Home
4	London Welsh "A"	Home
11	R.A. Shoeburyness	Home
18	Old Millhillians	Home
1921.		
Jan. 1	Southend	Home
8	Harlequins "A"	Home
15	Rosslyn Park "A"	Away
22	Rosslyn Park "A"	Home
Feb. 5	London Welsh "A"	Away
9	R.A.F. Uxbridge	Away
12	Old Alleynians "A"	Away
16	R.A. Shoeburyness	Away
19	Christ's Hospital	Away
26	Old Merchant Taylors	Away
Mar. 5	Edgware	Away
9	London School of Economics ...	Away
12	Old Elthamians	Away
16	R.N.C. Greenwich	Away
26	Old Blues "A"	Away
30	Cardiff 2nd	Away
Apr. 9	London County & Westminster Bnk	Away

ASSOCIATION.

FIRST ELEVEN.

1920.		
Oct. 2	Emeriti	Home
9	H.A.C.	Away
16	Harlesden Town	Home
23	Old Lancing Boys	Home
30	Cane Hill	Home
Nov. 6	Emmanuel Athletic	Home
13	Ongar Town	Away
17	City & Guilds College	Home
25	Colchester Town	Away
27	Emmanuel Athletic	Away
Dec. 4	Old Aldenhamians	Home
11	Old Johnians	Home
18	Old Bradfield Boys	Home
1921.		
Jan. 8	Old Owens	Away
15	H.A.C.	Home
22	Old Westminsters	Home
29	City & Guilds College	Away
Feb. 5	Old Citizens	Home
12	King's College	Home
19	Old Johnians	Home
26	The Forest Club	Away
Mar. 5	Harlesden Town	Away
12	Cane Hill	Away

SECOND ELEVEN.

1920.		
Oct. 9	H.A.C. "A"	Home
16	Emmanuel Athletic "A"	Away
23	Nestanglo Sports Club	Away
Nov. 3	St. Mark's College	Away
10	Royal Dental Hospital	Home
13	King's College	Away
20	Old Cholmelians	Home
27	East London College	Home
Dec. 11	London School of Economics ...	Away
18	East London College	Away
1921.		
Jan. 8	Old Cholmelians "A"	Home
15	H.A.C. "A"	Away
22	School of Pharmacy	Away
26	Royal Dental Hospital	Away
29	Old Monovians	Away
Feb. 12	King's College "A"	Away
19	National Provincial & Union Bank	Away
26	Nestanglo Sports Club	Home
Mar. 12	Alexander "A"	Away
19	School of Pharmacy	Away

Births.

POULTON.—On the 17th September, at "The Downs," Woldingham, Surrey, to Dr. and Mrs. E. P. Poulton, a daughter.

WILLIAMS.—At Fron Haul, Mold, North Wales, on August 23rd, the wife of Owen E. Williams, M.R.C.S., L.R.C.P., of a son.

Marriage.

OLIVER-FANING.—On August 14th, at St. Mary of the Angels, Bayswater, Grant Oliver, of 30a, Wimpole Street, to Bruna, second daughter of Dr. and Mrs. Eaton Faning, of 20, Queen's Gardens, Lancaster Gate.

The Sciences.

BIOLOGY.

The Biology course is primarily intended to be the students' introduction to the science of medicine, and must be regarded as the study of living things in many forms and from various aspects rather than the acquisition of facts about a number of plants and animals. In other words, it is intended as a training in the acquisition of a point of view rather than a stock of facts. Incidentally, also, the student learns a language which is largely his means of expression afterwards. The practice of the Biological Laboratory should give him a facility in the use of scalpel and scissors and a knowledge of methods of preparation and staining of tissues which are the arts of the Dissecting Room and the Histological Laboratory.

Lastly, a thorough acquaintance with the vertebrate types should be a great help to him in obtaining an intelligent knowledge of human anatomy. Cases of instruments are placed on view which include all those afterwards required in the Dissecting Room.

A microscope is needed from the beginning, and the student is warned against buying an instrument which will be a handicap to him throughout his career. The difference in price between a good and a bad instrument is only a few pounds. All second-hand microscopes should be submitted to the Demonstrators for inspection and examination of lenses before the purchase is completed.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so, is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required. but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasized, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open from 9 a.m. to 5 p.m. from Monday to Friday, and from 9 to 1 on Saturday, and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought. "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

ANATOMY.

The primary object of dissecting is to render oneself familiar with the structures of human anatomy and their relationships one to another. A good knowledge of human anatomy is essential to the medical student, owing to the great scope for application of this knowledge which is provided by medicine and surgery, and it is no exaggeration to say that the better a man knows his anatomy, the more likely is he to succeed in either of these subjects. By handling and tracing the structures exposed in dissections, the student is enabled to form mental pictures which greatly exceed in value the plates and diagrams to be found in books, and it cannot be emphasised too much that the knowledge obtained by dissecting is more thorough, more lasting and more definite than the knowledge obtained from text-books, however good the latter may be.

In addition, dissecting trains the fingers and develops the sense of touch, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is very desirable to possess a half skeleton. (This may be had from Mr. Hancock, the Senior Assistant in the Anatomical Department, who will also supply cases of instruments.)

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

Men who intend to take the Primary Examination for the Fellowship of the Royal College of Surgeons should attend both the course of lectures for senior students in the second winter session (for times, *vide* notices), and also the special class for the Primary Examination.

Books and Instruments.

The student requires a Manual of Practical Anatomy, in which the structures are described as they are exposed in the course of dissection. The best book for this purpose is Cunningham's Practical Anatomy (3 vols., 12/6 each); it should be read before during, and after each day's work.

In addition, a text-book of Human Anatomy, in which the subject is described by systems, is neces-

sary. Gray's or Cunningham's Text-Book are both good.

Men who think that they may want to take the Primary Examination for the Fellowship of the Royal College of Surgeons will require a book dealing with Embryology and Morphology, and they will find that Keith's book on the subject contains all that is essential.

The following instruments are necessary:—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are necessary.

Dental Students.

The detailed knowledge which is demanded of the medical student is essential for the dental student only as regards the head and neck and the bones of the skull. Special demonstrations are arranged each term suitable to the requirements for the L.D.S. Examination. Dental students should arrange their curriculum in such a way that the three terms which they are required to spend in the dissecting room are consecutive. The disadvantages of breaking up the course are very obvious, and quite outweigh any apparent temporary advantage that may accrue from doing so.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While attendance at physiology lectures and the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

During the first summer session and the first half of the second winter session the student should attend the lectures on Physiology (for times, *vide* notices), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, Howell's *Text-book of Physiology*, or Hill and Flack's *Text-book*. While attending the practical classes held during the winter, the student is advised to read *Practical Physiology* (published by Arnold).

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining a wider knowledge or distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Text-book of Physiology*, *Recent Advances in Physiology and Bio-Chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; *Principles of General Physiology*, by W. M. Bayliss; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the Demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

PATHOLOGY.

When the student has passed the Second Conjoint or M.B. Examination he is about half-way through his medical curriculum, and he should have gained a working knowledge of the functions of the body in health. This knowledge is an essential preliminary to the study of the most important of the medical Sciences, viz., Pathology, or the study of the functions of the body in disease. Throughout his life the student, if he continues to study and practise medicine, must ever keep pathology in the foreground. It is desirable, therefore, that the study of pathology be begun as soon as possible and continued throughout a medical career.

The subject is an exceedingly large one and it is customary to divide it into several sections:—

1. General Pathology.
2. Morbid Anatomy.
3. Morbid Histology.
4. Bacteriology.
5. Chemical Pathology.

Due attention must be paid to each of these branches.

During the first three months' work in the wards the study of pathology is commenced. Tuesday, Wednesday and Thursday mornings are occupied with lectures on the general principles of Pathology followed by practical work in Morbid Histology and Bacteriology. Regular attendance at these classes is most desirable, and the attractions of the Wards and clinical work should not be allowed to interfere with the laboratory studies.

Classes and demonstrations in chemical pathology should be attended during the tenure of the post of Medical Ward Clerk.

It is essential that throughout all ward appointments no opportunity should be missed of continuing the study of pathology. Every man should, as far as is practicable, follow out the pathology of each and every one of his cases. Is a bacteriological investigation made? He should follow it as far as possible. Is a portion of tissue removed for microscopical examination? He should see the section. Is a chemical examination demanded? He should try and see the analysis carried out. He should never miss an autopsy on any one of his cases. He should read up each case as he meets it. Set hours cannot be given for these lines of study, they must be fitted in as time and opportunity permit.

Efforts should be made to see as much practical work and as many demonstrations in pathology as can be arranged. There are very few days when no pathology can be learned. Post-mortems are held nearly every day — Monday, Tuesday, Wednesday, Thursday and Friday at 2 p.m., and Saturday at 12 noon. Attendance at these will amply repay the time expended.

Informal classes in pathology are held twice weekly during the October and May terms (Monday and Friday at 9.30 a.m.). These, though primarily intended for M.B. students are suitable for all and should be attended by those sitting for Part I. of the M.B. Cantab. and the Final M.B. of Oxford or London University.

During the later clinical appointments certain students may hold a few pathological posts, such as Student Demonstrator, Assistant to the Demonstrators of Morbid Anatomy, Student Assistant in the Bacteriological Department. One or more of these may be held in turn, and they prove exceedingly valuable from the learners' point of view.

There are many books which might be recommended, and what suits one man does not prove attractive to another. MacCallum, "Text Book of Pathology"; Pembrey and Ritchie, "General Pathology"; with Muir and Ritchie, "Manual of Bacteriology," should prove an adequate combination for most purposes. Other books which may suit other tastes and which are good are—Adami, "Principles of Pathology"; Adami and Macrae, "Text-book of Pathology"; Green, "Pathology." For morbid histology Grunbaum "Essentials of Morbid Histology" may be recommended.

When the information in these books proves inadequate, as it is sure to do occasionally, some of the articles in Allbutt and Rolleston "System of Medicine" may be consulted, or references to original papers may be obtained from that work, and from the bibliography in MacCallum, "Text-book of Pathology."

BACTERIOLOGY.

From the preceding paragraphs it will be seen that elementary practical instruction forms part of the work of the newly appointed Ward Clerk, and as such is intimately associated with clinical medicine and surgery, on the one hand, and post-mortem study on the other. From the student's point of view microscopical pathology now occupies some 120 hours compressed into an appointment of three months' duration (Surgical Ward Clerk) instead of being extended over a period of six months, and more stress is laid upon the correlation of microbic activity and histological changes.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus, and morbid exudates by various methods to demonstrate the associated bacteria. In addition, he is instructed in the practical work of culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced courses which are available during later years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis, which experience has shown are both reliable and valuable. Demonstrations are also given upon the life history of the various organisms pathogenic to the human race and the changes such organisms undergo or produce when they gain entrance to the human tissues.

During February and March of each year a course of lectures is given dealing more technically with the applications of bacteriology to practical diagnosis and treatment. These should be attended at a somewhat later period, since they deal with the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treatment of disease, together with those facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

CLINICAL CHEMISTRY.

A class is held in this subject during the period of first three months medical ward clerk, forming part of the course in pathology. Students are recommended to make an early acquaintance with this subject in order that they may carry out investigations of this nature on their own cases, for which purpose accommodation is provided both in the clinical laboratory and in the laboratory of clinical chemistry.

MEDICAL WARDS.

To each medical ward clerk is allotted a certain number of beds, and he is expected to examine, and write full reports on all patients who are admitted into these. Occasionally it so happens that a patient is too ill to be examined except by the house-physician and physician, or that a case dies or is discharged before the ward clerk has had an opportunity of seeing it. Under these circumstances he should obtain the history, and an account of the symptoms, physical signs, and progress of the case from the house-physician, and should base his report on these data. It cannot be too strongly insisted that a report, however brief, must be written on every case, and it is of the greatest importance that the diagnosis and remarks made by the Physician should be entered at once into the report. Moreover, any errors detected by the Physician or Registrar in the original report should be immediately corrected. In the event of a patient dying the ward clerk must obtain the abstract of the post-mortem findings, and carefully enter it up, and it need hardly be said that all clerks should make every effort to see the post-mortem examination on any case they may have seen during life.

The medical wards are open to clerks from 10 till 12.30 in the morning, and from 1.30 till 5.30 or 6 in the evening. The Registrars begin their rounds at 10.30, and by that time a clerk should at least have full notes of the history

of any new patient who may have been admitted into one of his beds; and he should have a full report in readiness for the Physician in the afternoon. Ward clerks should realise that they are expected to know the details not only of their own cases, but of every patient under their Physician. It is no excuse to plead ignorance because "this is not my case." If only a clerk will take the trouble to make himself conversant with each case in this way, he will find at the end of his six months that an enormous amount of clinical material has passed through his hands, and he will probably have acquired enough knowledge of medicine to enable him to pass the Conjoint Final with but little additional reading. But so many men waste their time through sheer laziness in the medical wards, never realising that they are throwing away experience which would prove invaluable to them later on.

An hour spent in the wards after tea three or four times a week will give opportunities, not only for going over cases and writing up reports, but also for seeing the house-physician tap chests and abdomens, etc. The treatment, too, which each case is receiving, may well be studied at this time.

As regards reading, the best method is to study the text-book account of each disease as one comes across it in the wards or in discussion, and afterwards to compare, if possible, the text-book description with the symptoms and signs presented by the patients. At the same time, the most important medical journals should be read regularly, for by this means only can the student keep himself in touch with modern work. The *B.M.J.* and *The Lancet*, as well as the *Journal of the American Medical Association*, are especially recommended.

Books that may be recommended are the following:—The well-known text books by Taylor and Osler, "Medical Diagnosis," by Latham and Torrens (a most valuable work), and "Auscultation and Percussion," by Gee. For second three months ward clerks Dieulafoy's "Text-book of Medicine," the most important monographs in Allbutt's "System of Medicine," and Campbell Thomson's "Diseases of the Nervous System," will prove valuable and interesting reading. For laboratory work Hutchinson and Rainey's "Clinical Methods," or Dr. French's book may be useful for reference.

SURGICAL WARDS.

The appointment of Surgical Ward Clerk is held for three months. It is the first, and possibly the best, clinical appointment. The ward clerk has a very definite responsibility, not only in recording the history and progress of his cases for future reference, but also in making observations which may be of vital importance. In this way the knowledge he acquires is the more certainly impressed. Each clerk is attached to a surgical unit, and works in the wards under the direction of the surgeon to whom he is attached and the registrar of the unit.

During this appointment the student attends a course in elementary pathology and pharmacology, and receives a grounding in the principles of disease and treatment. At the same time he cannot be too strongly recommended to take every advantage of his opportunities to gain an insight into that practical work which will stand him in good stead, not only as a surgical dresser, but throughout his professional career. He should make a point of spending all his available time in the Surgery during "take in" week, and of seeing major and minor operations and even dressings whenever possible.

The responsibility of writing careful reports is too obvious to labour; no clerk with a grain of common sense will regard a surgical report merely as an educational exercise for his own benefit.

Two further periods of three months are devoted to the appointments of Surgical Dresser. The work of a dresser is perhaps of more importance at Guy's than at any other hospital, and the advantages to be gained are correspondingly greater. A dresser has only to realise this to prove himself worthy of the trust and reap the benefits.

The most junior clinical student has a definite status in the wards, and he will find his opinion as an anatomist or physiologist treated with the greatest respect. That he should occasionally be called upon to do some of the "dirty work" is inevitable; but no reflection is cast thereby on his standing.

We have only briefly indicated the main points in the work of a surgical dresser. He will receive a copy of the "Standing Orders" relative to this and each other appointment he may hold. The hospital expects, and rightly insists, that he shall pay strict attention to these orders, since he is no longer an irresponsible student, but for the time being one of the cogs in the wheel on whose integrity the smooth running of the hospital depends. With growing knowledge comes growing responsibility, and he must show himself worthy of the trust reposed in him.

THE CHILDREN'S DEPARTMENT.

Physician-in-Charge, Dr. Cameron.
Chief Clinical Assistant, Mr. A. A. Osman.

In-patient accommodation.—Dr. Cameron has under his care 12 cots, which are housed in Miriam, the surviving part of the Clinical Wards. On one day in the week, at present on Tuesdays at 11 a.m., Dr. Cameron goes round the ward and gives clinical instruction.

Out-Patient Department. — Children under 7 years of age are seen in the Children's Department at Out-Patients on Mondays, Wednesdays, and Fridays from 9.30 until 1 o'clock. Dr. Cameron attends on Mondays and Fridays at 10 a.m., when clinical instruction is given.

The Salomons Centre for the care of the mothers and children of the Midwifery Charity is now completed.

NEUROLOGICAL DEPARTMENT.

MEDICO-NEUROLOGICAL CLINIC.

The arrangements for the Medico-Neurological Clinic for the Winter Session are not finally settled, but they will be approximately as follows:—

(1) *Elementary Ward Teaching at 2 p.m.* Monday and Friday, Dr. Hurst; Thursday, Dr. Hunt; Tuesday, Dr. Symonds (Neurological).

(2) *Advanced teaching for senior students and post-graduates only at* 10.30 *a.m.* Monday, Dr. Hurst and Dr. Hunt; Friday, Dr. Hurst and Dr. Symonds (Neurological).

(3) *Clinical Demonstrations at* 12 *noon.* Mondays, Medical, in turn, Dr. Hurst (gastro-intestinal), Dr. Hunt (circulatory), Dr. Marshall (tuberculosis), and Dr. Barber (dermatological); Wednesdays, *Neurological,* Dr. Symonds, 1st 3rd and 5th Wednesdays, Dr. Hurst, 2nd Wednesday, and Dr. Craig, 4th Wednesday; Fridays, *Medico-Surgical,* Dr. Hurst or Dr. Hunt with a surgeon or specialist.

(4) *Out-Patients.* Medical, Tuesday, Dr. Hunt; Neurological, Wednesday and Friday, Dr. Symonds.

THE DERMATOLOGICAL DEPARTMENT.

Out-Patient Days.—Tuesday, 10.30 a.m. (children), 1.30 p.m. (adults). Thursday. 9.30 a.m.

The Physician in charge of the Department also sees selected old cases, which require special investigation or treatment, on Wednesdays at 1.30 p.m., and anyone desiring to carry out a research in the Department may arrange with patients to attend at this time for the purpose of investigation.

Wards. There are three male and three female beds in the Medical Wards for dermatological cases requiring careful supervision or treatment in bed.

Instruction in the diagnosis and treatment of diseases of the skin is given in the Out-Patient Department, and clinical demonstrations on selected cases are held from time to time.

THE AURAL AND LARYNGOLOGICAL DEPARTMENT.

This Department is organised on the unit system. There are two units, one under the care of Mr. Mollison, the other of Mr. Layton. Patients are seen in the Out-Patient Department, admitted when necessary to the special wards, Ruth and Barnabas, and returned to the Out-Patient Department. This arrangement allows members of each unit to follow up the cases. Mr. Mollison's firm sees out-patients on Tuesdays and Fridays at 12 noon, Mr. Layton's firm on Mondays and Thursdays at 12 noon.

Dressers are appointed to the respective firms, and have every opportunity of becoming expert in the technique of examination of the ear, nose and throat, and gain experience in diagnosis and treatment. Large numbers of school children are seen, and about 1,000 minor operations are performed in the Out-Patient Department a year; of these the great majority are for the removal of tonsils and adenoids: these operations are performed by the dressers under the supervision of the Surgeon or the Clinical Assistant.

Eighteen beds are now allotted to the Department and each firm operates twice a week. Mr. Mollison and Mr. Layton "take-in" during alternate weeks and emergencies are admitted under the care of the firm on duty.

THE OPHTHALMIC DEPARTMENT.

The Ophthalmic Department of the Hospital is in charge of the two Ophthalmic Surgeons. They are helped by two Assistants, two House Surgeons and Dressers. The dressers are appointed four times a year for a period of three months, and assist the Surgeons at Out-Patients and at operations, and are responsible for the recording of the cases both in the wards and at Out-Patients. The Ophthalmic Department is an open field for any student to explore as far as he is willing and able, the amount of clinical work being sufficiently great for him to see all the more ordinary and common diseases of the eye in the space of three months.

The student will soon find that he is quite unable to form any opinion of his own, on an ophthalmic case, until he has mastered the use of the ophthalmoscope and can readily and accurately decide what is the refraction of the eye, and if the "fundus oculi" is healthy and normal. The theory of retinoscopy can be taught and is simple; the practice, however, requires constant application by the student before he can hope to obtain any sort of facility in it. The difficulties are mainly initial ones, and any time and trouble expended in mastering them will well repay any man in after life when he has qualified and is in practice.

The Ophthalmic House Surgeoncy is one of the most important in the Hospital, as the Ophthalmic House Surgeon is not only in charge of the Ophthalmic beds, but also of Ear, Nose, Throat, and Orthopædic beds, so that his experience is wide and his responsibility great.

THE ORTHOPÆDIC DEPARTMENT.

The Orthopædic Department comprises a large out-patient clinic and ten beds devoted to patients suffering from deformity. Out-patients are seen on Monday and Wednesday afternoons, and in the Out-Patient Department the student will meet with every variety of deformity, congenital and acquired. Considerable facilities are afforded for experience in the relief and cure of all chronic diseases of bones, joints, muscles, etc. Instruction in the principles and most modern practice in the use of appliances, plaster technique, and the more useful forms of physio-therapy is given by Mr. Trethowan, the Orthopædic Surgeon, and Mr. Todd, the Orthopædic Registrar. Numerous operations of a minor nature are done, such as manipulations for stiff and painful joints, correction of mis-shapen and ricketty limbs, plastic correction of scoliosis, and plastic immobilisation of tuberculous joints.

The in-patient beds are devoted to the most serious operative cases, such as extensive tendon transplantations, correction of mal-united fractures, bone-grafting, the making of new joints, etc. Guy's is

a pioneer in possessing an excellent workshop for the manufacture of every form of splint and appliance.

It is in the Orthopædic Department that the principles underlying the mechanical disabilities of the limbs and spine are emphasised and their explanation made clear, and the experience to be gained here is invaluable. The great utility of orthopædic surgery has become evident to very many during the war, and the extensive orthopædic administration now devoted to the care of pensioners will almost certainly merge into some big national scheme for the care of vast numbers of crippled children.

THE GENITO-URINARY DEPARTMENT.

Students acting as Dressers in this Department have excellent opportunities of acquiring knowledge which will be useful to them in actual practice and examinations. Out-patients are seen on Tuesday and Friday afternoons.

There are eight in-patient beds, six in Astley Cooper Ward and two in Queen Ward. During the past year attention has been paid in particular to congenital abnormalities of the lower urinary tract, and it is hoped that some progress has been made in the treatment of these important and distressing conditions. Students should realise that their attendance at this out-patient department, though not compulsory, is very necessary, as is evidenced by the very advanced state of disease in which some patients arrive for examination.

THE MASSAGE AND EXERCISE DEPARTMENTS.

These Departments are working on Monday, Tuesday, Thursday and Friday from 2.30 p.m. to 4.30 p.m., and on Wednesday and Saturday from 9.30 a.m.

Clinics are given by Dr. Hunt on Monday and Friday and by Mr. Trethowan on Wednesday and Saturday. The work done of interest to medical students consists: *In the Massage Rooms*, the after treatment of fractures, dislocations, stiff joints, nerve injuries, rheumatoid arthritis and deformities. *In the Exercise Rooms*, the result of progressive muscular work on every type of case can be watched, as all muscular disability is transferred at the earliest possible moment for re-education. Good results have been obtained in a large number of heart and lung cases, and here the students interested may have an opportunity to do further investigations.

Students who wish to attend in this section of the Hospital can do so on a request to the Sister in Charge, who is in the lower massage department at 12.15 daily.

THE OBSTETRIC DEPARTMENT.

After finishing appointments in the Medical and Surgical Wards the student is posted to the Obstetric Department for six months. During the whole of this period he is also attached to the Physician for Children's Diseases. The Obstetric Dresser is responsible for case-taking in the wards and at Out-Patients, assists at operations, and during one month acts as Extern in the Maternity Charity. The Department has twenty-two beds reserved for gynæcological cases and eleven beds for the reception of cases presenting complications in pregnancy, labour and the puerperium. As an intervening link between the Obstetric and Children's Departments is the Salomons Centre, in which the health of mothers and infants is fostered by the practice of preventive medicine. The scope of the work done outside the wards is indicated by the fact that last year 2,400 attendances were recorded at Obstetric Out-Patients, while 3,500 women were attended in confinements in their own homes.

With this wealth of clinical material available it should be possible for every student to obtain a sound knowledge of methods of diagnosis and treatment founded on no small experience. It must be confessed that this desideratum is not always attained and the cause lies partially in a fundamental defect in the medical curriculum. Passed through the hands of a succession of specialists, the student is apt to develop a compartmental mind: the filling up of a buff transfer slip is all the consideration which he is prepared to give to a case with gynæcological symptoms. It cannot be too strongly urged that a wider outlook on Medicine should be cultivated, and that the study of the symptoms of diseases peculiar to women should be begun from the outset of a student's clinical training. The man entering the wards who hopes to become a complete doctor should include among his initial purchases a book on Gynæcology and should make a point of attending the systematic lectures given by the obstetric surgeons during the summer session. He should also avoid no opportunity of acquiring the "tactus eruditus" so essential to the diagnosis of pelvic disorders. The inherent impossibility of permitting a class of students to examine women one after another renders it imperative that this experience should be gained over a considerable period of time.

The study of midwifery he may well leave until he becomes an obstetric dresser, and it is hoped that in the near future he may be provided with still greater facilities for learning this art.

THE TUBERCULOSIS DEPARTMENT.

(Dr. Marshall).

The Tuberculosis Department is a reference department for out-patients suffering from diseases of the chest. Patients attend on three days in the week, Tuesday and Friday afternoons and Wednesday evenings. In suitable cases arrangements are made for admission to sanatoria. The patients return to the Out-Patient Department after leaving the sanatorium. The Department provides extensive opportunities for studying methods of investigating early and doubtful cases of pulmonary tuberculosis, also for observing some of the special forms of treatment for diseases of the lungs.

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must known is how to write a prescription; it may even be necessary for the majority, when

qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The student is taught practically the methods of prescribing, he practices writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

DENTAL SCHOOL.

The Dental Student is supplied at the Medical School Office with the Prospectus, Standing Orders, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Notices regarding the time and place of Lectures are to be found posted up at the main entrance of the Dental Department.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

First and second year students need only those instruments necessary for Prosthetic work, and are advised not to purchase instruments used during their clinical period of study (third and fourth years) until the commencement of the third year.

Among the various depôts at which instruments may be purchased are the following :—Claudius Ash, Sons & Co., Broad Street, Golden Square, W.C.; Dental Manufacturing Co., Alston House, Newman Street, W.; and Cottrell & Co., 15, Charlotte Street, W. 1.

First and second year students have a simple routine to follow. Their work is confined chiefly to Dental Prosthetics, but Chemistry and Physics and Dental Metallurgy are also studied and should be passed, the first two subjects during the first year the third during the second year.

The student will come into actual contact with Hospital patients during his second year, and he should always endeavour to be punctual in his appointments with them. There is nothing more irritating and annoying to a patient than to be kept waiting unnecessarily; it also delays to a very great extent the easy working of the Department. Further, the student should remember that the cultivation of a courteous and gentle manner towards his patients will become in the future probably the greatest asset in his private practice.

Third and fourth year students commence their clinical courses with a two months' period of probationary work upon the phantom head. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These operations upon the dummy form an excellent ground work in operative dentistry.

Thereafter the course of work consists in holding and diligently carrying out the work of the following appointments:—*Probationary Dressership in the Conservation Room; *Dressership in the Conservation Room; *Dressership in the Children's Department; Dressership in the Ordinary Extraction Room; Dressership in the Gas Extraction Room; Casualty Dressership; Clerk to Anæsthetist.

A student, apart from those holding the post of Assistant Dental House Surgeon or Clinical Assistant, and men up for Part II. of the Final Examination for the L.D.S., is not allowed to work in the Conservation Room unless he holds one of the appointments marked *.

Dental students will profit by following the practice of the Special Departments of the Hospital, *e.g.*, Eye, Throat, Ear. They will also have numerous opportunities of observing the more remote effects of dental disorders in the General Wards and Out-Patient Department.

Students in difficulties about their work and needing advice are invited to consult the Dean, Sub-Dean, Resident Dental Officer, or any other member of the Staff, who will be pleased to do what they can to promote the interests of students.

OSTEOLOGY.

The question of the purchase of bones is always an important one. Millikin & Lawley, in the Strand, make a speciality of supplying the medical student with this part of his equipment.

BOOKS.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first. The number of text books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co., publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co., Philip & Son, Cassell & Co., Nisbet & Co., and Baillière Tindall & Cox.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the Hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Prince of Wales' Empire Tour, which terminated in so happy a fashion on Monday last, has been one of the great events of the week. His reception by the public, which has learnt to appreciate his great gifts and his striking personality, was almost unparalleled, and all Guy's men will wish to associate themselves very heartily in welcoming home their President after so long an absence. As an Empire Maker the Prince has already made his mark. He has now expressed his wish to turn his attention to the many problems of reconstruction which are harrassing the Mother Country. Not least of these is the question of the future of the Hospitals, and we, at Guy's, are proud and glad to have as our President one whose ability in public life has been so surely proved in the past year.

THE medical press during the last two weeks has been full of references to the new session which started on October 1st. The medical correspondent of *The Morning Post* calls to mind the fact that until the end of the last century the great Medical Schools all made a great feature of the Opening Address. Such addresses are given at some hospitals even at the present time, and were given at Guy's until a comparatively recent date. But although the custom of giving an opening address has fallen into disuse, its place at Guy's has been taken by the Inaugural Address of the Pupils' Physical Society which is delivered at the first general meeting of the Session and which, unlike the ordinary meetings of that Society, is intended for all students at whatever stage of their studies. A notice of this year's Inaugural Address will be found on page 363 of the present issue of the GAZETTE, to which we direct the attention of our readers.

We notice that a similar function is to mark the first meeting of the Abernethian Society at St. Bartholomew's Hospital. In making an announcement of this meeting, the Editor of the "St. Bartholomew's Hospital Journal" claims that the Abernethian Society is the oldest of its kind in London. Members of the Guy's Physical Society cannot allow such a statement to pass unchallenged. The Physical Society was founded in 1771. It is true that its constitution has been altered, but the tradition remains, and we are proud to claim our Society, founded when John Abernethy was only 7 years old, as the oldest Medical Society in London, if not in England.

OUR attack upon the Examination system in the Students' Number has stimulated Dr. Samways to send a defence of examinations, which will be found in our correspondence columns. We must confess ourselves unconvinced by Dr. Samways' letter. We said that the "existing system had few merits." Dr. Samways objects to this as "unjustifiably severe" and then proceeds to make much of those few merits

which we thought too obvious to state. No one denies that examinations make a man read. But he reads solely with a view to passing his examination. We never intended to suggest that there should be no examinations at all. Any system will compel a student to grind away at what he finds dull and uninteresting. We cannot agree that the present system takes much consideration of such qualities as "health, responsiveness, common sense, pace and method." Any man possessing them together with "a sufficient knowledge of his subject," certainly stands a good chance of getting through, but the fact that he has got through is absolutely no proof that he possesses all or any of them. Dr. Samways points to Hospital Staffs and Consultants as evidence of what our examination system can produce. We have an immense respect for these learned gentlemen, but they will forgive us if we are unable to accept their academic distinctions and successes as evidence of the excellence of the examination system. For they are exceptional men — we had almost said super-men. They would distinguish themselves under any system of examination, and perhaps the present system affords them greater opportunities than could any other. A farmer selecting eggs for the market can easily tell the difference between the very good and the very bad. Obviously those laid to-day are very good; those laid before the war very bad. But he will not find it so easy to determine the merits of the vast majority of intermediate ones. So it is with examinations. In discussing a system of examination, the superlatively good and the deplorably bad men may be ignored. To distinguish between the possibilities of the ordinary run of students is no light task, and we maintain that experience has proved the failure of the existing examination system.

We noticed recently in the daily press an account of a meeting of Guardians to consider the question of disposing of the bodies of unclaimed paupers by permitting them to be used for anatomical purposes. The Guardians by quite a large majority decided against the unclaimed bodies being used for such purposes. The Chairman of the meeting, a clergyman and evidently a very sensible fellow, tried hard to dissuade his fellow Guardians from following so irrational a course, but without success. He pointed out that doctors could not be trained without ample facilities for dissection and that the objections raised were all of a hopelessly sentimental and utterly ridiculous nature. He further darkly hinted that if all Boards of Guardians persisted in such a course, the once popular pastime of body-snatching and even wholesale murders might be revived. However that may be, it is quite clear that there must be an adequate supply of bodies if anatomy and operative surgery — the latter an increasingly important factor in the health of the nation — are to be properly taught. At present the situation might almost be termed critical, and some anatomical departments are quite unable to cope with the large demand for bodies brought about by the phenomenal number of men at present studying medicine. The present Minister of Health, Dr. Christopher Addison, was himself once a Professor of Anatomy (at St. Bartholomew's Hospital), and he is doubtless well aware of the difficulties in which medical schools are now placed by the shortage of dissecting-room subjects. That this crucial matter is under his consideration is evidenced by the fact that he has recently appointed Dr. Alexander Macphail, Lecturer on Anatomy at St. Bartholomew's Hospital, as a Medical Officer of the Ministry of Health. Dr. Macphail's first duties will be the administration of the Anatomy Acts which has recently been transferred to the Ministry from the Home Office.

In the current issue of the *Medical Press and Circular* we notice an indignant contribution from a surgeon who had just undergone an abdominal operation, in which he complains of the great pain that he and all his fellow-patients at the nursing-home suffered on the days following the operation. We imagine that it is unusual for a surgeon himself to undergo

an operation, on the same principle that makes most butchers vegetarians and most brewers teetotallers. But it must be a valuable experience for a surgeon who does countless operations weekly to suffer one himself occasionally. Possibly it is done as a routine at the Mayo Clinic. It would certainly be an interesting experiment for, say, all the surgeons at the Hospital to be operated on by their respective Assistant Surgeons and to suffer after-treatment at the hands of their own H.-S.'s.

But, in all seriousness, the article in the *Medical Press* raises some interesting questions. The writer, "An Ex-Hospital Surgeon," is concerned with that most distressing condition of flatulent distension which is so common when otherwise all is well. He believes that this complaint, "which may amount to almost unendurable agony," could always be prevented by more rational methods of preparation. In the first place he considers the total emptying of the large bowel unnecessary except in certain cases, *e.g.*, resection or short circuiting, and even in these the required result could probably be obtained with an enema. His chief complaint against the orthodox preparation is that after the oil, given on the penultimate day, full diet is allowed until the morning of operation. Thus after the final enema, "not only have most of the patient's digestive juices been swept out of his system by the purgative, but three substantial meals have been introduced in addition into his stomach and bowels which the latter are largely unable to digest." Further, the patient's digestion will be again upset by the anæsthetic and the I.M.H., if any. He mentions two cases of "acute appendix" which were admitted during his stay in the Home, both of which were operated on, as a matter of urgency, without any "preparation," and in neither case was there any post-operative distension or any appreciable post-operative vomiting. His remedy is to abolish purgation and to trust to the enema. Or if purgation is considered essential, to allow no food between the purge and the operation except a little fresh fruit juice.

Christmas is approaching, but as yet we see no signs of preparations for the Residents' Theatricals. We have heard vague rumours and we hope that another Christmas will not be allowed to pass without the revival of so worthy and time-honoured an institution. For what is Christmas at the Hospital without the Theatricals? Your niggers and your ward concerts are all very well, but it was the Theatricals that gave to the old Christmas festivities their special character. Besides, the Staff must from time to time be reminded of their idiosyncrasies; and there have been several new members of that august body since 1914.

Talking of Christmas, the Choral Society wishes us to draw the attention of our readers to the fact that practices are to be held every Friday at 8 p.m. in the Court Room. They are hoping to do some carols for Christmas, and to give a concert later.

We are very grateful to Dr. Percy Allan for sending us a case from his practice for commentary. This is an excellent innovation, and we hope it will be extensively followed by other old Guy's men in general practice. We hope that many solutions to Dr. Allan's case will be sent us for insertion in our next issue.

We are indebted to Mr. Davies-Colley's House Surgeon for the following letter. For the benefit of the printers it has been transliterated from the original. In some cases there was some doubt as to what the letters actually were, but the probable letters have been inserted wherever there was any question. Most of it was, however, fairly legible, but its exact interpretation is still largely an open question. Here it is:—

Hearbert G———
Ribben 23
Lawn rod
Northfleet Kt

please Mr Davies-colley I hame riting thes few lines to you asking you if you Will be so king to send me a stifek on be half of my me tha you tending to me of tascles and I whent under a k ropishen and won stakel tuy out and miy inpler Want to now if it was don biy foling down on the shovel cowes it and if you Wod be so kind send me a stifek Mr Davies-colley I did not have aney trobey be fore come down on the shovele be cols miy inpler Will give me a litle to pay for miy expesenes I cow not ford to pay it out of my onepocket I have got fore childrn and miy silf and mother to Work for and I get fiftey five shiling to kepe them

send back as sun as you ken be cols thay want it biy nex tusday

The Modern Surgical Treatment of Tropical Abscess of the Liver.*

CLINICAL LECTURE BY Major C. H. REINHOLD, F.R.C S. (Ed.), I.M.S.,
In charge of the Surgical Division of No. 45 Indian General Hospital, Abbassia.

Gentlemen,—Tropical abscess of the liver is a disease which has forced itself on the notice of the medical profession other than those whose practice is in the East, owing to the vast numbers of men that we have thrown into the Field in the recent Great War, and its wide geographical distribution; and it behoves every general practitioner at home to be prepared to meet this condition in the near or distant future, and deal with its emergencies.

Practically all the cases have come from the armies in Gallipoli, Mesopotamia, East Africa, and Palestine, and some from the Territorial Forces which were stationed in India during the War. Sir Ronald Ross, as early as November, 1915, anticipated a large increase in the incidence of this disease as the result of the dysenteries of Gallipoli, where more than 32,000 cases occurred, but the Medical Advisory Committee, with Colonel W. Hunter at its head, was of opinion that the Bacillary type was by far the predominant variety, and probably accounted for four-fifths of the cases.†

Ætiologically, tropical abscess of the liver may be said *always* to be the result of amœbic dysentery.

Often the context is obscure; the dysentery may have occurred months or years before, and have been apparently cured; or it may have been so slight as to be mistaken for diarrhœa, and been forgotten or overlooked. In a few cases liver abscess is thought to have been primarily due to the entamœba histolytica without any antecedent bowel trouble. Sometimes it has occurred in cases where the precursor has been diagnosed as bacillary dysentery, but Sir Ronald Ross is of opinion that in these cases the amœbic character of the dysentery has been missed, and the case has only been seen in the "post-amœbic colitis" stage, when amœbæ are no longer found in the stools; but an autopsy would show amœbic ulceration of the bowel. Some cases have undoubtedly been mixed infections of the amœbic and bacillary type. As regards the frequency of liver abscess as the result of amœbic dysentery, Sir Leonard Rogers collected the statistics over 10 years from all British troops in India, and found it occurred in 14 per cent., or one-seventh of all cases. Some other facts of interest in the ætiology of this condition may be elicited from the race and sex incidence.

The primary cause—dysentery—was at least equally common among all races—British, Indian, and Egyptian, under like circumstances, but liver abscess is very much more common among Britishers than Orientals; it is also very much more common among men than women. There is undoubtedly some predisposing cause in the European diet which is absent in the Oriental, and this is probably the meat factor; also alcohol is a potent cause which affects the sex incidence.

An interesting side-light on the effect of alcohol was thrown by an Egyptian surgeon who told me that most of his cases hailed from the Assiut district where the production of arak was a large industry, and intemperance is not uncommon.

Trauma and chill, especially the latter, are further potent predisposing factors; thus the disease is more prone to occur at the beginning of the cold season. Malaria can only be said to predispose in that it lowers the general vitality and allows the amœba more chance of gaining a footing.

The Morbid Anatomy of this condition commences with hyperæmia and congestion of the liver followed by a breaking down of the liver tissue, which cannot be described as a true suppuration, but rather a liquefaction and necrosis due to some specific action of the entamœba histolytica; the so-called pus is of a thick treacly consistency and has the classical chocolate-brown colour which is recognised as pathognomonic of liver pus. The pus is sterile, and there is often difficulty in recovering the entamœba from it, though Rogers claims that it may be seen in almost all cases if swabs from the walls of the cavity are carefully examined, and Manson has demonstrated that it can frequently be recovered from the discharges a day or two after operation, whereas

*Delivered before Junior Officers of the R.A.M.C. in Cairo, April, 1920.

†A later report of the Medical Advisory Committee reversed this conclusion and expressed the opinion that the amœbic form of dysentery was the predominant type in Gallipoli.

it was absent at the first. This is the ideal pus; but in old-standing cases or where the abscess is near the surface of the liver facing the bowel it is frequently infected with bacillus coli and may have a fæcal odour instead of the mawkish smell associated with the classical case. In other cases the pus may be thin and yellow, though still sterile, if the abscess has become encysted.

The abscess is more commonly single than multiple, in the proportion of 3 to 2, according to Zancarol, though other observers have placed the proportion of single ones much higher. When single it may attain a very large size, and I have myself aspirated such an one containing 50 ounces of pus. It is more commonly in the right lobe of the liver than the left owing to the greater bulk of the former, nearly 80 per cent. of the cases occurring in the right lobe.

As regards *symptoms*, the onset is generally insidious and frequently determined by a chill long after the antecedent dysentery has been apparently cured. The patient feels out of sorts and has a foul tongue and no appetite, and he feels a sense of weight and discomfort in the epigastrium. This is the stage of congestion. Fever is often absent at first, but eventually makes its appearance in the form of an evening rise, preceded by shivering and followed by the most profuse drenching sweats; the temperature does not reach a great height, and rarely exceeds 102° F. The skin assumes a dull earthy colour, but jaundice is uncommon. Pain is of a dull boring character and is often referred to the right shoulder through the association of the phrenic nerve with the fourth cervical in the neck. An acute stabbing pain is generally an indication of the abscess being near the surface and causing perihepatitis with consequent inflammation of the adjacent peritoneum, either diaphragmatic or abdominal. If the diaphragm is irritated there may be a dry cough, and a pleuritic rub may be heard at the right base on auscultation.

The spleen is not usually enlarged. The liver is felt below the costal margin, but the tendency is for the enlargement to occur mainly upwards, and a dome-shaped area of dulness may be made out at the base of the right lung.

X-ray examination may be very useful in the early stages in revealing this tendency, and also to demonstrate deficient movement of the right side of the diaphragm. Later an increased density of the liver shadow is an indication of the point or points of abscess formation.

The liver is tender on palpation, and any spot of acute tenderness, such as is sometimes found in the interspaces of the ribs, is of great use in localising the abscess; sometimes a localised patch of œdema indicates the site for exploration.

The bowels are generally irregular, either constipated or loose, and flatulence is common. The blood-count shows a marked polymorphonuclear leucocystosis, and is a valuable aid to diagnosis in excluding malaria in which the leucocytosis is mononuclear, and the graver anæmias, such as leucocythemia and pernicious anæmia, in which an exploratory puncture would be a very dangerous proceeding and might easily be followed by fatal results.

The differential diagnosis has to be made from pyæmia, pylephlebitis, hydatid, malaria, and the graver anæmias just mentioned. The first three are less important than the last, as the line of treatment by surgical intervention might be the same; the anæmias should be excluded by the absence of a typical history and a careful blood examination, as already mentioned.

But is it remarkable how frequently these cases are mistaken for malaria, and Osler states that he has rarely seen a case which has not previously been drenched with quinine under this false impression. This should not occur, since, apart form the cytological differences already mentioned, that is to say, a polymorph instead of a mononuclear leucocytosis, a case of malaria of such intensity with quotidian fever, even though there was an enlarged liver from malarial hepatitis, would be bound to have a very much more enlarged spleen, and one would expect to find that organ extending at least three fingers' breadths below the costal margin. Moreover, the fever in malaria generally occurs earlier in the afternoon than the evening hectic fever of liver abscess.

Again, the fact that intensive quinine treatment is not affecting the course of the fever should set the practitioner on the right road, since so great an authority as Manson states that "no uncomplicated ague resists quinine in full doses."

The Treatment of liver abscess has been considerably modified of recent years, since the introduction of emetine by Sir Leonard Rogers in 1912; indeed, it may almost be said that these cases are being taken out of the hands of the surgeon into those of the physician. Emetine, as you know, is the most active principle of Ipecacuanha, and one grain of this drug is the equivalent of 90 grains of Ipecacuanha; moreover, despite its name, it has considerably less of the emetic properties of Ipecacuanha, even when used hypodermically. It appears to have a specific action on the entamœba histolytica, and since its introduction amœbic dysenteries have been much more efficiently treated, and the sequel of liver abscess has become less common. Moreover, in the early stages of abscess, vigorous treatment with hypodermic doses of emetine in doses of one or two grains daily has caused absorption and averted the necessity for operative treatment; and, lastly, it has considerably simplified operative procedure, so that the open operation as described in the textbooks is giving way to one of simple aspiration.

The surgeon, having decided that his patient is suffering from liver abscess, must proceed to locate the pus, and in the absence of localising symptoms, the most likely place in which to make a successful exploration is in the eighth right interspace in the anterior axillary line, and in a direction backwards and slightly upwards.

This should be done on the operating table, since one must be prepared to carry straight on in the event of pus being found. The needle should be one of large calibre and not less than four inches long, and affixed to a syringe with a clear glass barrel; it should be driven in to the full extent before negative pressure is applied by withdrawing the piston of the syringe in the barrel; if pus is not at once struck, the needle should be slowly withdrawn, still under negative pressure, as the abscess may have been transfixed. If nothing is found, trial should be made in other directions, and the search should not be abandoned until at least six punctures have been made. Even if this has failed, it is remarkable how sometimes the patient is benefited by these acupunctures, and I have in mind a case which showed all the classical symptoms of liver abscess with hectic, drenching sweats, and a tender enlarged liver, where several punctures failed to find pus, but the patient's symptoms were relieved by this treatment and a liberal use of emetine hypodermically, and he subsequently got well without operation.

When pus has been located, *aspiration* should be the treatment preferred in all cases where it is possible, and this should be done with the aspirator and vacuum bottles familiar to you all in dealing with pleuritic effusion, always combined with vigorous use of emetine hypodermically; Rogers recommends three or four daily $\frac{1}{2}$ gr. doses.

If the abscess cavity is large, some surgeons inject a few ounces of Tr. Iodi (a drachm to a pint), or Quinine bihydrochloride (10 grains to the ounce), for their antiseptic or germicidal properties, but here again Rogers favours emetine hydrochloride (1 grain to the ounce) for its specific action on the entamœba which he has shown flourishes in the walls of the cavity.

The needle should then be withdrawn and the puncture sealed with collodion.

The risk of infection of the pleura or peritoneum through the needle track is largely theoretical, and should not deter one from this simple procedure in favour of an open operation, and even if the cavity refills, as happened in one of my cases, re-aspiration should be done rather than an open operation with its attendant risks of sepsis and a mixed infection, for it must be remembered that the pus in these cases is usually sterile, and that is the justification for not opening the cavity up to infection from without.

If the pus stinks and is found to be highly infected with bacillus coli, however, it will probably be advisable to do an open operation and drain the cavity from the bottom. The needle should be left in situ as a guide, and an incision made parallel to the rib; the hole in the liver should be gently enlarged with sinus forceps followed by the finger and, unless a flat metal drainage tube is available, it will generally be found necessary to resect a portion of the adjacent rib to admit of a rubber tube being inserted without compression. Even if the abscesses are multiple, with the aid of emetine and aspiration of the main one, a good prognosis may be hazarded, as the smaller ones often become absorbed and cause no further trouble; but sometimes this happy result does not take place and fever continues, necessitating further search, and perhaps an abdominal section and palpation of the liver from within. Here again, in the event of the ab-

scess being found, first refusal should be given to aspiration wherever possible, though it will generally be necessary to open and drain the cavity after, in case of re-accumulation; but the rubber tube should be dispensed with as soon as possible if symptoms abate.

If thorough search of the right lobe with the exploring needle has failed to find pus, or relieve symptoms, the abscess will probably be in the left or the lobus Spigelii, and in these cases blind search through the unbroken skin is too risky, and recourse must be had to an abdominal incision and liver palpation. The prognosis, as you may readily imagine, is not so good in these cases as when the right lobe is the seat of the trouble.

I have recounted to you average cases of a subacute type which are fortunately the common type, but sometimes the disease is fulminant with rapid destruction of liver tissue and infection of the abdominal cavity with general peritonitis, which must be treated — though rarely diagnosed beforehand—on general lines, and the prognosis is bad. In others the progress is slow, and the pus may track in a most remarkable way, thus only recently we have had two case in 45 I.G.H., in one of which liver pus was evacuated from under the trapezius muscle at the shoulder, while in the other the abscess was opened in the gluteal region.

This is all I have to say, Gentlemen; my special plea is that, since the introduction of emetine, the surgery of liver abscess should be a minor operation for choice, but of course one should always be prepared for a major one when necessary, and I think that the efficient treatment of this grave condition should not now cause alarm and despondency to a general practitioner, as it might justifiably have done ten years ago.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Examination System.

SIR,—In your article in the issue of October 2nd, your strictures on the Examination System seem to me unjustifiably severe. You say "the existing system has few merits," whereas the converse is far nearer the truth.

The purpose of examinations is to discover a man's knowledge by his power of presenting that knowledge. It is the same test which is applied in everyday life, and it is for everyday life a man is trained and examined. Accumulated knowledge, which a man cannot reproduce at an examination, does not justify success. In after life he will also have to know how to apply his knowledge when the occasion calls for it. Encyclopædias and text-books are not wanted at the bedside, but a resourceful man.

To pass an examination a man must have a sufficient knowledge of his subject; in addition he requires health, responsiveness, common sense, method, pace and other qualities. So he does in life. Men who break down in health at examinations generally deserve to. They overwork at the end, or commit other follies, which in after life would also incapacitate them. An irresponsive candidate will be a nuisance later to his patients. A man without method and common sense will not go far, and is best pulled up and taught that fact at the start. If he takes his paper of questions and commences laboriously to answer the first, perhaps to him the most difficult, before reading the others, all of which he might have answered while struggling with the one, he will gain few marks because of his own stupidity. This is not that the system is faulty, but rather because it is sound. A slow man, too, is rightly handicapped.

A hospital education is training a man for his life's work. So are the examinations, which reward for knowledge applied as well as knowledge acquired.

A second good feature about the examination system is its influence on study. It forces a man to learn what he does not like as well as what he does; what comes with trouble as well as what comes with ease. With me Physics was always child's play, but Chemistry was a grind, and the innumerable formulæ a torment. I am thankful examinations compelled me to work at Chemistry. The knowledge that there will be examinations forces men to balance their studies, to learn with the idea of reproducing their knowledge, to get forward with their work, and to anticipate an early recognition and reward, if satisfactory.

Our hospital staffs and consultants are largely chosen from men specially successful in examinations. They have proved that the early test gave, on the whole, a faithful forecast of their fitness for their posts.—Faithfully yours,

D. W. SAMWAYS.

Small Pox.

DEAR SIR,—I thought these photos of some of the cases of small pox recently under my care and reported in the GAZETTE of August 7th might be of interest.

I am indebted for them to Dr. Allingham, to whom I express my thanks. Photos 1 and 2 are of case 35, photo 3 of case 36, and photo 4 of case 37.

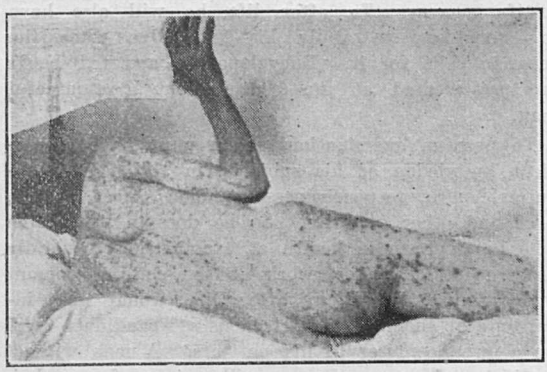


Photo 1.—Case 35, male, aged 60. Taken 11 days after appearance of first rash. The first rash was vesicular, but the second rash which came out eight days later was partly spotty. The photo shows the profuseness of the first rash on the back and secondary on the forearms.

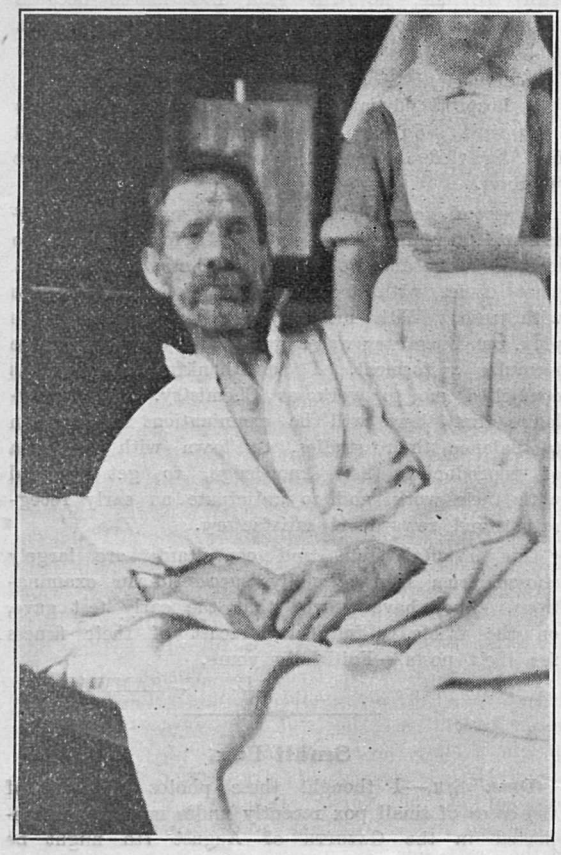


Photo 2.—The same case showing rash on face.

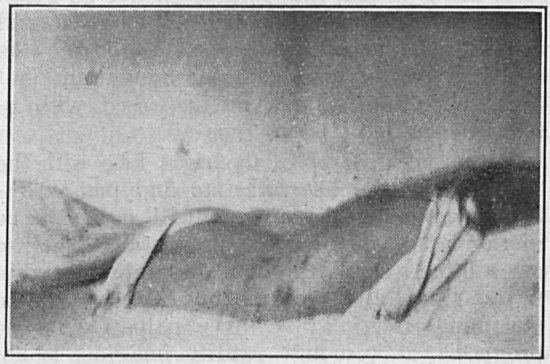


Photo 3.—Case 36, female, aged 61. Sister-in-law of Case 35. Back showing similar but much milder attack. These two cases were diagnosed as either Alastrim or else Modified Small-pox. They had both been re-vaccinated within a few days of admission.

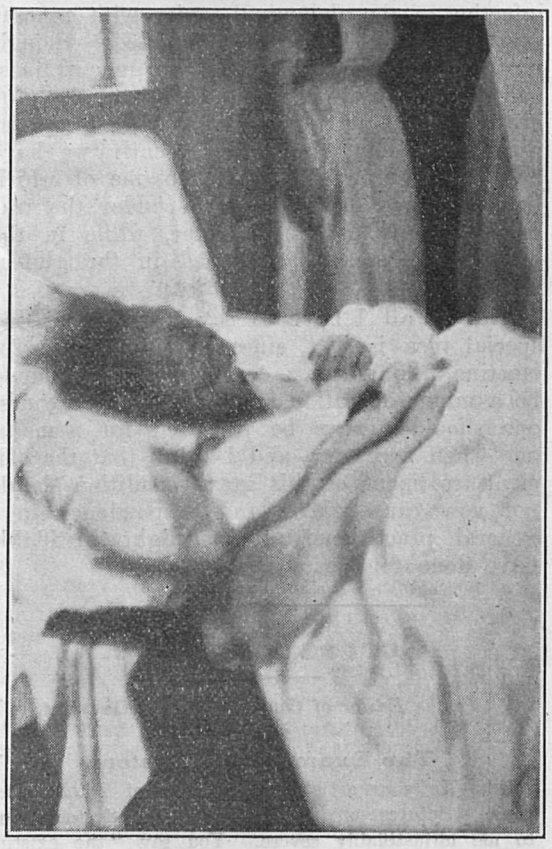


Photo 4.—Case 37, female, aged 19. Unvaccinated. Photo taken a day before her death. Shows the deep discolouration of face and swelling.

Yours sincerely,
STEPHEN FLOYD.

Bismuth and Magnesia.

Dear Sir,—Dr. A. Percy Allan's paper in Guy's Hospital Gazette of September 18th, page 316, suggests to me to send you the enclosed.

I did two consecutive locums for two neighbouring doctors, both successful and well established practitioners.

Doctor No. 1.—Prescribed Liq. *Bismuthi* et a.c. in almost every prescription, whether the symptoms were bronchial, stomachic or rheumatic, &c. He had a large variety of drugs in his surgery, and used four or five in each prescription.

Doctor No. 2.—Used very largely *Magnesia* emulsion and no Bismuth at all, for he had found that the Magnesia powder mechanically did all that the Bismuth did, that it was antacid, and that instead of causing constipation it helped on the evacuations, especially in children. He had very very few drugs in his surgery, and used very few at one time. His mainstays were a febrifuge of Sod. Salicyl. and Liq. Am. Acetatis; Ammon. Carb.; Tr. Nuc. Vom.; Tr. Opii and Tr. Zingib., etc.

A. WITHERS GREEN.

29th September, 1920.

5th County of London (Yeomanry) Armoured Car Company.

Dear Sir,—It is thought that the formation of Armoured Car Companies from certain Yeomanry Units is not, at present, generally known, and that there is a possibility of many ex-Territorials and others, who would be only too glad to join.

This Company, the 5th County of London Armoured Car Company, has been formed from the 3rd County of London Yeomanry.

I believe that three of the chief advantages of joining this branch of the Territorial Force are:

(1) Having an opportunity of learning to drive and maintain motor cars.

(2) Each crew, consisting of five or six men, will work together, and when fully trained will have the care and maintenance of their own armoured car. This alone should induce a few friends to join together and form a crew.

(3) Being able to serve as a Territorial in His Majesty's Forces, in what was considered one of the most interesting branches of the Army, during the Great War.

As an old Yeomanry Officer, I therefore make this appeal, hoping that, on due consideration, some of your readers may care to join, and that I shall be able to form a company similar to and as efficient as the late 3rd County of London Yeomanry.

I shall be only too pleased to give you further information, or, should you care to do so, kindly write to the Adjutant, Headquarters, 5th County of London (Yeomanry) Armoured Car Company, Henry Street, St. John's Wood, London, N.W.8, for particulars of service.—Yours faithfully,

D'ARCY FRANCIS, Major,
Cmdg. 5th County of London (Yeomanry) A.C. Company.

Guy's Hospital Nurses' League.

On Monday, October 4th, the Photographic Section of the Nurses' League gave a Lantern Lecture in the Nurses' Home, entitled "With Allenby through Palestine, with a Watch Pocket Carbine." The lecture and 80 slides were kindly lent by Messrs. W. Butcher & Sons, Ltd., and a large audience was keenly interested in the vivid little pictures of life during the Palestine campaign.

On Wednesday, October 6th, at the Nurses' Cottage, Honor Oak Park, a very enthusiastic company assembled to watch the final of the "Fagge Lawn Tennis Cup Nurses' Singles" played by Nurse Winifred Johnson and Nurse Sylvia Vian. The match was well fought, and contained some exceptional rallies. Nurse Johnson's fleetness of foot gained her some difficult points, and the sets ended 6—1, 6—4; in her favour.

The Matron, Miss Magaret Hogg, speaking from the verandah, said that there had been over a hundred entries, and owing to bad weather and the holidays, the Cup Ties begun in the spring had taken the whole summer to play off. She thanked Mrs. Fagge, on behalf of the entire nursing staff, for her great interest in the Tennis Section of the League, and hoped the Nurses would show even greater enthusiasm in the various sections of social intercourse which the League offered, since Nurses above all should endeavour to have as wide an outlook as possible. She called on Mrs. Fagge to present the Cup to the winner, Nurse Johnson. Mrs. Mollison's prize of two guineas also went to the winner, and a half-guinea consolation prize to Nurse Vian.

Mrs. Fagge, in reply, said she hoped that someone present might one day win a replica of the Cup outright. Three hearty cheers were given for Mrs. Fagge, Mrs. Mollison, and Mrs. Cosmo Bonsor, the President of the Nurses' League. A great many of the Sisters and Nurses were present, and the weather was ideal.

On the night of Wednesday, October 6th, a very successful Swimming Gala was held by the Swimming Club of the Guy's Hospital Nurses' League. The performances were on a brilliant scale, and thrilling to the spectators, and we can only hope that they were as much enjoyed by the performers. Much amusement was caused by the uniform race, which demanded both courage and ingenuity, and perhaps the prettiest event was the candle race, held in darkness, and the winner, who swam two lengths of the bath with her candle unextinguished, is much to be congratulated. The band was most zealous, and added very much to the festivity of the evening. The proceedings were brought to a close by a charming speech from the Matron, who thought the swimming almost too good, and hoped that next year we should have many more competitors of the kind who can only just struggle across the bath. Mrs. Trethowan most kindly presented the prizes to the successful competitors. The prizes were the gift of Mrs. Trethowan, the Matron, and an anonymous friend, and were awarded as follows:—

1. Flat Race (Nurses).—1st Prize, Nurse R. Fitchett; 2nd Prize, Nurse Dudfield.

2. Flat Race (Sisters).—Prize, Sister E. M. Pickard.

3. Surface Diving.—Prize, Nurse Dudfield.

4. Uniform Race.—1st Prize, Nurse Potter; 2nd Prize, Nurse Dudfield.

5. Diving.—Prize, Nurse R. Fitchett.

6. Fancy Dress.—Prize, Nurse Leggatt; Dress Prize, Nurse Courtenay.

7. Candle Race.—1st Prize, Nurse Dudfield; 2nd Prize, Nurse Cornwall.

Nursing News.

The Cazenove Gold Medal for 1919, awarded to the Probationer who gains the highest total of marks in the Practical Nursing, Medical, Surgical and Nursing Examinations, has been awarded to Nurse Winifred M. Stansfeld.

The "Keogh" Prize for highest number of marks gained in the Surgical Examination: Probationer R. Ingram.

Prize for highest number of marks gained in the Medical Examination: Probationer H. Gration.

Prize for highest number of marks gained in the Nursing Examination: Probationer R. Ingram.

We regret that in our last issue we omitted to mention that students and others can get any medical work they want at the cheapest possible prices at Ellis's Lending Library, 9, Lovell's Court, Paternoster Row, E.C.4., and that the Medical Library there, provided by Mr. Ellis, offers many advantages worth attention.

Obituary.

A correspondent from Victoria, B.C., sends us a copy of the *Victoria Daily Times* of September 2nd, which contains an announcement of the death of one who must have been the oldest living Guy's man. Dr. J. S. Helmcken was born in 1823, and, although originally destined to be a teacher, became apprenticed to a Dr. Graves in Trinity Square, and later entered as a student at Guy's Hospital, which he left with a licence from the Society of Apothecaries. After a sea voyage he returned and "took his Conjoint," or at any rate got diplomas from the Colleges. He went to Victoria in 1850, and was later made the first magistrate in the Colony. He had many adventures in this capacity with refractory miners and Red Indians, but his great administrative capacity overcame all the troubles of his difficult and responsible position. In 1852 he married the daughter of Sir James Douglas, the second Governor of the Colony. Four years later he was elected to the first Legislative Assembly of Vancouver Island, and he delivered the first political address in the Colony. He was chosen as Speaker in the same year, which post he held until the union of the Colonies. After the union he sat for Victoria City, and in 1869 he was called to the Executive Council. He took a leading part in the Confederation controversy. In 1871 he represented Victoria on the Council of the Confederation, but refused the offer of the Speakership. After declining a Senatorship, he retired from public life in 1871, and after twenty years' residence, during which time he had been the leading political figure in the Country, devoted himself to private practice. The fact that the *Victoria Times* refers to him as the "Grand Old Man of Vancouver Island" is a striking testimony to the respect and affection in which this great alumnus of Guy's was held by his fellow men. He had been a widower for many years, and only two daughters out of a family of seven children survive him. One son was a doctor, and another a K.C. He leaves ten grandchildren and eight great-grandchildren.

We regret to have to record the death of Dr. Robert Denman, M.R.C.S., which took place at his residence at Kew on October 1st. Educated at Marlborough, he entered Guy's in 1879, and, after qualifying, practised for some time in Bournemouth. He then entered the Colonial Medical Service, and was at one time Health Officer at Mauritius. He contracted malaria in the tropics, but only retired from the Service a few years ago, when he went to live at Kew. He died of cardiac angina—the end coming suddenly, thus saving him a lingering

and painful illness, of which he had a dread. He was a man of even temper, a good sportsman, keen cricketer, and made and retained many friends. He leaves a widow and one son to mourn his loss.

Pupils' Physical Society.

A General Meeting of the Pupils' Physical Society was held in the Residents' Room at 6 p.m. on Tuesday, September 28th, when the following gentlemen were elected presidents for the ensuing year:—Messrs. Payne, Shaw, Maizels, Mark Brown, O'Meara, Coburn, Hodgkinson, Gill Carey, Rogers, Braithwaite, MacKeith, Douthwaite, Massie, Leviseur, Reeves, and Watson.

The inaugural address will be delivered by Dr. Lauriston Shaw on the afternoon of Thursday, 28th inst., and will be preceded by the usual display of books and instruments by Messrs. Grattan and Messrs. Down Bros. Tea will be served in the Wills Library at 5 p.m., when the books and instruments can be inspected. The Address will be delivered at 5.30 p.m. in the Physiological Theatre.

J. GAYMER JONES.
G. B. DOWLING.
Hon. Secretaries.

Guy's Hospital Medical School.

The following Entrance Scholarships have been awarded:—

Senior Science Scholarships for University Students.

War Memorial Scholarship.—£75, Nils Lövold Eckhoff, University of Cape Town; £80, Harold Charles Beccle, University College; £35, George Thompson Henderson, B.A., Gonville and Caius College, Cambridge.

Junior Science Scholarships.—£120, Reginald Albert Nash, Preliminary Science Class, Guy's Hospital; £50, Alfred Beresford Plant, Preliminary Science Class, Guy's Hospital.

War Memorial Scholarship (Providing a free Medical education for five years, annual value about £40).—Kenric Charles Billingham, Brighton, Hove and Sussex Grammar School.

Entrance Scholarship in Arts.—£100, Edward Ian Ransford Marsden, Cheltenham College.

Civil Appointment.

St. George Bernard Delisle Gray, M.B., B.S. (Lond.), to be Medical Officer in Charge of the British Hospital, Oporto, Portugal.

Case for Commentary.

P.B., æt. 46, served in Boer War and for home service during the late war. Tall, strong and healthy. He suffers from peculiar attacks, which come on *suddenly*, with palpitation, shortness of breath, pyrexia, and an erythematous rash. He has had four attacks in all. One came on in the Army & Navy Stores suddenly, and, having lost consciousness, he was taken to a military hospital. Here he was seen by two medical officers and a cardiologist in consultation. No diagnosis was made. Later when seen in attacks the military authorities discussed "trench fever," and on one occasion they were puzzled as to whether the rash were scarlet fever or not. The attacks have come on at about six months intervals, and between he is perfectly well. When taken ill he feels a sudden sinking, "as if the life were going out of him," his eyes ache, and there is intense pain at the back of the eyes. He has never been bitten by lice.

I was called to him on 29th September, and found him in bed complaining of severe headache, pain in eyes and in back and limbs. He had the appearance of one in pneumonia—flushed, dry skin, eyes bright and glassy, pupils very small. He felt intensely hot, but the temperature was only 100°. Bowels opened the day before. He felt desperately ill and had dyspnœa. Pulse 100 regular but small. No physical signs in chest or abdomen. He did not sleep all night, and in the morning his condition was unchanged, except that he was covered with an erythematous rash, much resembling "scarlet," but not punctiform, and there were white islands in places, like urticaria, but the rash was not raised and did not itch. I ordered him castor oil and a sleeping draught. Next day he was better; had passed a large but normal motion; temperature 99·4°. After this he gradually recovered, and got about. On 9th October I was sent for—nine days after the original onset—and found him in bed with the same rash, but no other symptoms; temperature 98·4°. He slept the following night, and is now all right again. The urine is quite normal. Now these attacks, occurring at such long intervals, hardly suggest bacterial infection, and I thought of parasites—hydatids or worms. With regard to the latter, the motions I have seen are good, and no ova have been discovered by an expert. The blood count, however, shows an increase of the eosinophiles, as follows:—

			Normal.
Small Lymphocytes	= 26·3 p.c.	41 p.c.	30 p.c.
Large "	= 14·7 p.c.		8 p.c.
Polymorphonuclears	=	51 p.c.	60 p.c.
Eosinophiles	=	7·3 p.c.	2 p.c.
Mast. Cells	=	·7 p.c.	—
		100 p.c	100 p.c.

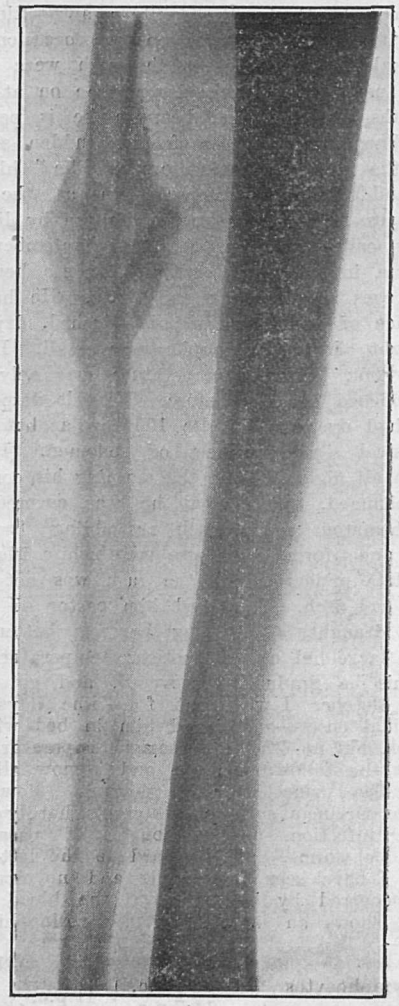
A. P. A.

Fusiform Swelling in Upper Third of Fibula.

The following is of interest in that it illustrates how the absence of previous history may render the diagnosis of a case most difficult.

Patient. Richard D., æt. 40.

Previous diseases. Unimportant. No history of syphilis. No history of former accident. No history of typhoid.



History of present complaint. Two days before admission the patient was at work at the docks, when half a ton of timber which was being transferred to a ship hit the outer aspect of his right leg a short distance below the knee, and pinned the leg to the side of the ship.

Condition on admission. A moderate amount of bruising present on the upper and outer aspect of right leg. On the upper third of the fibula a tender swelling could be palpated. Pain on walking.

The X-ray photographs reveal a fusiform swelling in the upper third of the fibula, the nature of which was doubtful, as it seemed fairly obvious that it could not have formed in the two days that had elapsed from the time of accident.

The possibilities discussed were:—

(1) Old trauma—the history of which it was impossible to elicit.

(2) Some tumour of bone, e.g., fibrous, sarcoma, or secondary carcinoma.

(3) Syphilis.

(4) Chronic inflammation.

The usual primary seats of carcinoma were examined without result.

No metastases could be found.

The Wassermann was negative.

There was no history of any pain or inflammation.

The X-ray favoured callus, especially as fragments of displaced bone were evident, and this was thought to be the correct diagnosis.

As a precautionary measure the man was advised to attend at frequent intervals, so that any change in X-ray appearance could be noted and acted upon if necessary.

I have recently seen a plate taken some five weeks after the injury, and there is no change except that the fracture was more evident, and it was apparent that it involved the old callus.

I am indebted to Mr. Rowlands for his kind permission to publish this case.

J. GAYMER JONES.

Reviews.

Military Sanitation: A Handbook for Soldiers. By Col. Robert J. Blackham, C.B., C.M.S., C.I.E., D.S.O., etc. (Messrs. John Bale, Sons & Danielsson, Ltd., London) 3rd edition; pp. 136, figs. 20; price 10s. 6d.

This is a good book. Let it be understood that any criticism in this review is intended in a constructive not in a destructive spirit, and is rather a suggestion how its value may be augmented than as a depreciation. And first on the word "sanitation." To many this brings to the mind only the subject of short-hoppers or cesspools in civil work and of manure disposal in military. Not so in this book; it includes, as it should, the whole subject of prevention of disease, whether dealing with the individual under the heading of personal hygiene or with the mass under the heading of public hygiene. The book is intended for the guidance of combatant and other non-medical officers, but may well be used by any young medical officer, and indeed by any young medical man pitchforked out into the world to deal with the myriad subjects in contact with which he never comes during his hospital life.

It is probable that anyone who has had much experience during the recent war will turn at once to the louse problem in a book such as this; it is well discussed, but we should have liked a little more detail. With regard to inspections, we do not believe that the M.O. can efficiently inspect every man of a battalion every week if he is to do his other work properly. The inspection must be done by company, or, better still, platoon commanders. The presence of the M.O. is needed to teach the combatant officer and to see he does it efficiently. For this he need not be present at every inspection, and it is enough if he sees every man once a month, as he can easily do if he attends the inspections of one company each week. We should like to have seen put down in detail some scheme of inspection for the guidance of young officers. We believe that the hairs around the anus and gluteal folds are sites where nits are frequently allowed to escape notice, and stress should be laid on the point or it will be missed. We are great believers in the efficacy of weekly returns. By them the responsibility of young officers can be brought home to them, and slackness can be checked. In the best administered unit with which the writer had to deal—an R.E. company—every section commander reported weekly to his O.C. that every man in his section had, *inter alia*, (a) been inspected for lice, (b) had a bath, and (c) washed his shirt and socks. The arrival of Friday morning tended to warn everyone how quickly the time had fled by the imminence of the time at which the weekly return had again to be rendered. Returns, however, are useless unless they are properly rendered. At a time when the division was badly lousy one battalion was sending in a percentage return weekly of about ten to twenty, while others sent in a return of sixty to eighty. This did not tally with the condition of the men as they were arriving at the field ambulances. It was found that the C.O. and M.O. of the battalion had distinguished between men infected and men infested. They had been asked to send a return of those infested, and they accordingly only counted such men as were—in common parlance—"decidedly chatty." This shows the importance of terminology, and it is well that there is now recognised a definite distinction between "disinfection" and the "disinfestation" of clothes. Before leaving the louse problem, we note that Col. Blackham does not draw attention to their spread during a sea voyage in a crowded trooper, and therefore the urgent need of all ranks to pay particular attention to the subject immediately upon landing in a new country.

The hygiene of the march is dealt with well, and we have seldom seen anything better than the description of boots and socks in this volume. But there are two subjects upon which we do not think Col. Blackham has entered into sufficient detail, nor has he been dogmatic enough nor firm enough about them; and in a book written for combatant officers these are shortcomings, for they are subjects upon which combatant officers are ignorant and are disinclined to give way; we refer to the physiological needs for fluid and to the weights carried.

Water discipline is an important piece of training, and its need must be impressed upon the mind of every soldier; but there are combatant officers who imagine that water discipline will enable troops to perform feats which entail a suffering that it is not in the power of average human nature to bear, and

to carry on to such a time that the man can no longer function as a physiological animal. We know of a memorandum which was circulated urging that officers and men must so develop their self-control that they could go for 48 hours on a single water-bottle during August in a sub-tropical climate. This was sent round in all good faith, and was altered to 24 hours as soon as the physiological facts were put forward. Subsequently a second water-bottle per man was issued before active operations started. This is an example of the want of knowledge on this point, and there is little or nothing in this book to counteract it. When we consider the varying needs of different individuals, we do not believe that two pints is enough fluid for all men over and above what he takes with his food. To some we believe that this is a quantity which would soon react upon their health. In another place it is stated as "3½ to 5 pints daily of which about one-third is contained in solid food." This is better, but in yet another place it gives "2¼ to 4 pints daily." This variation of quantities is not helpful to the young platoon commander faced with complaints from his men with which he has to deal fairly, nor to the young R.E. officer who suddenly finds himself with a detached force and is faced with the problem of estimating the needs of six thousand men and two thousand horses. Great things have been done in the last war on the half-gallon ration, but we maintain that this is the irreducible minimum, and that it must be increased so far as possible on every possible occasion, and even then no allowance is made for washing. We maintain that a commander who starts on any operation even for 48 hours without being absolutely assured of this supply is courting disaster. We believe that many senior combatant officers do not know this; we suspect that certain disasters in the late war may be attributed to it. It is the business of the medical service to teach this to the other services before the outbreak of another war.

So also with the weight that the soldier carries. From reading Col. Blackham we might infer that he acquiesces in the weight of 69 lbs. 15 ozs. which he gives in a table or even in that of 80½ lbs. which he mentions. Personally the writer has known troops carrying over 100 lbs. These estimations are made when the clothes are dry and clean; they make no allowance for rain or for mud. Now we maintain that 56 lbs. is the maximum which the man should carry if it be desired that he remain fit and mobile, that the members of our corps must never tire of pointing this out to the combatants, and never give their approval to any kit which weighs an ounce more. The staff must learn that if they insist upon the men carrying more they must take the responsibility of ordering it against the advice of the medical experts and not with their acquiescence. Our experience leads us to believe that the combatants are ignorant on this point, and that they are not only ignorant but unsympathetic. Until this is changed they will never face the problem of cutting down the weight to a maximum of half a hundred-weight. We can well imagine that a divisional commander in the late war at the request of his Q officer signed an order saying that stern disciplinary action would be taken with anyone who put more than the proper load on a pack-mule or a camel, and then turned to his G staff officer and acquiesced in an order which said that the most over-loaded beast of burden in the Army—the private soldier—should carry a Mills' bomb in each pocket during the forthcoming operations.

We have dwelt at length on these points because they deal with mobility, and mobility of the infantry in the end decides the campaign. In Allenby's leap to Aleppo we heard of the doings of the Anzac, the Indian and the British cavalry, of the Arabs and the light armoured cars, yet the thing that made this a stategic advance and not a mere cavalry raid was the fact that the 3rd Indian Infantry Division was foot-slogging as hard as it could go with the 54th British behind it to Haifa, to Acre and to Beyrout, but of them we heard nothing.

When this war started no one dreamt of the development of trench warfare; what the next war will bring forth no one can promise to deduce. We can envisage a small force sent on in fleets of aeroplanes to seize a strategic point, we can imagine a larger one rushed up in lorries to help them hold it. But it will ultimately be in the hands of that side which can get up to it a sufficient force of infantry, and this will still mean "poor bloody Tommy" as Mr. Gilbert Frankau calls him foot-slogging across the hills and the plain.

T. B. LAYTON.

6th October, 1920.

The Pharmacopœia of the Queen's Hospital for Children, Bethnal Green; Compiled by a Committee of the Staff (Messrs. H. K. Lewis & Co., Ltd., London) sixth edition, 1920.

This little book is much like other Hospital Pharmacopœias in that it contains the usual mixtures, liniments and other concoctions that are commonly used to deceive the general public—not that the medical man wishes to deceive his patient; but the patient will never be satisfied that he is being "treated" unless the bottles that he brings with him (or her) are suitably replenished. The addition of an admirable appendix dealing with the feeding of babies and the care of children generally gives the work a very definite use, and its contents should prove of value to nurses, students, health visitors and other interested in infant welfare. The volume is excellently printed and tastefully bound.

Venereal Disease and its Prevention. By R. Le Blanc, M.R.C.S., L.R.C.P. (Messrs. G. W. Browne, Letchworth, 1920) price 7s. 6d.

We have rarely sat down to the task of reviewing a book with a greater sense of the difficulty of our task. Mr. Le Blanc has set before himself the noble and almost Augean labour of eradicating Venereal Disease. If we must confess that he has set about it in no Herculean fashion it is not that we do not recognise the many merits of his work. In four parts devoted respectively to Anatomy and Physiology, Gonorrhœa, Syphilis and Prevention he sets forth what he considers that it is essential for the man (and woman) in the street to know. He mentions the ætiology and all the more important symptoms of Gonorrhœa and Syphilis in language which, if it does not reach a high literary level, is certainly easily intelligible. Under treatment he, rightly, lays stress on the importance of early advice from a qualified medical man. It is the chapter on Prevention which will probably be most criticised. Here, naturally, the whole question of prophylaxis versus continence, which has recently been so prominent, is raised. Mr. Le Blanc professes himself to be no moralist and to have written his book on preventive medicine with no ethical considerations whatever. Without wishing to enter into the controversy, both sides of which have sufficiently ventilated their views in the past few years, we must confess to some degree of disappointment that Mr. Le Blanc has thought fit to adopt capital letters only for the words "early and prolonged treatment." We recognise, as do all medical men, the supreme importance of early treatment. But we feel strongly that it is the duty of the medical man to preach continence first, prophylaxis and treatment second; and that on the former by far the greatest stress should be laid.

There is no question that the education of the public in venereal diseases is a matter of extreme urgency. In so far as Mr. Le Blanc's book may succeed in doing this it will be of value. But there is something about its style and general tone that makes us think that it is not likely to appeal to the English mind. At any rate, it will probably do no harm, but, honestly, we cannot imagine any father giving it to his daughter to read.

A Synopsis of Medicine. By H. Letheby Tidy, M.A., M.D., B.Ch. (Oxon.), F.R.C.P. (Lond.); price 26s.; and *A Synopsis of Surgery* (illustrated). By Ernest W. Hey Groves, M.S., M.D., B.Sc. (Lond.). F.R.C.S. (Eng.) (Messrs. John Wright & Sons, Ltd., Bristol) 5th edition, 1920; price 17s. 6d.

"Hey Groves" is so old a favourite that to commend it is superfluous. The fifth edition has been brought up to date and greatly improved by the addition of a number of line drawings, chiefly of splints and their application, and some new plates to the chapter on surface markings. The colouring of the more important structures in these plates adds greatly to their clearness, as does the better quality paper which has been adopted throughout. War Surgery has been adequately dealt with, and the student will find the new edition even more helpful than the old for the work of rapid revision.

With *A Synopsis of Medicine* Messrs. Wright are presenting a new volume to medical literature. Its aim and scope are the same as in the companion *Synopsis of Surgery.* The book is very full, and, with the arrangement of its sections based on that in Osler, it will be of great value for revision work. Dr .Tidy is to be congratulated on producing a worthy fellow to "Hey Groves," and Messrs. Wright on their enterprise in filling a long-felt want in this particular branch of the students' library.

It must, of course, be understood that neither of these two works is intended to replace the standard text-books. But in preparation for examinations, when time is short and previous knowledge must be rapidly reviewed, the student is justified in adopting methods which would be highly unsatisfactory if used in an attempt to acquire that knowledge in the first place. If this fact is borne in mind, "Hey Groves" and "Tidy" will be a pair of books of considerable usefulness for examination candidates.

Synoptic Chart of Cardiac Examination, arranged by John D. Comrie, M.A., B.Sc., M.D., F.R.C.P.E. (Messrs. John Bale, Sons and Danielsson, Ltd., London) 2nd revised edition, 1920; price 4s. 6d. net.

This ingenious device has come to our notice now for the first time. The Chart consists of a diagram of the Thorax printed on a stout card in which various holes are cut in the position of the heart valves and elsewhere. Behind the card is a movable slide on which is printed matter placed so as to correspond to the holes in the Chart. By adjusting the slide so that, say, "Aortic Incompetence" appears at a gap in the left side of the chart a comprehensive view of the physical signs (and pulse tracing) is displayed through the other apertures in the chart. Altogether it is a most fascinating toy which will afford any student a pleasant relief from the more conventional methods of acquiring knowledge. But it is more than a toy, and can be safely recommended to the medical ward clerk as a means of dispelling many of those mysteries of cardiac examination which are usually so persistent and so troublesome.

Into an accompanying pamphlet of 16 pages Dr. Comrie has attempted to compress the salient facts

about the physical signs of heart disease. Its very brevity inclines us to recommend it to the student with less confidence than the chart. Sufficient emphasis has not been laid on the fact that physical signs are merely the interpretations of certain pathological changes in the heart, and undue prominence is given to the valvular lesions. It is rather startling to read of Simple Endocarditis that "a murmur due to this lesion causes very slight incompetence." There is already so great a tendency for the student to put the cart before the horse that authors should be exceedingly careful not to encourage it by carelessness of phraseology. But if the student will take the letterpress *cum grano* we think that 4s. 6d. expended on the Chart will bring in a good return for his money.

Common Infections of the Kidneys with the Colon Bacillus and Allied Bacteria. By Frank Kidd (Messrs. Henry Frowde and Hodder & Stoughton) price 18s.

It is some time since we read with such keen interest a book written with such original ideas as the above. Not only is the book written with great skill, but it is one full of instruction and presents many points for mature consideration. Mr. Kidd is to be congratulated in breaking away from the "narrow groove" and giving his readers a wider scope upon which to meditate. He challenges the Bacteriologist at the commencement in his Introduction —"Bacteria are not *the* cause of bacterial infections," but are the exciting cause; the body tissues are not the sterile tissues that some would have us believe, but rather that the body is a sponge which is constantly absorbing minute doses of bacteria, and that these doses in varying amounts together with some predisposing cause bring out some signs or definite symptoms in the body. In this manner the blood is invaded daily by bacteria, and so Kidd revolutionises Adami's theory that such is a rare phenomenon. Kidd bases his evidence on the exploration of the human body rather than experimental researches on animals. Whilst acknowledging the works of others such as Young, Adami, Wright and Lane, Kidd criticises in no mean manner when he considers that such authors have gone beyond their facts.

The book is divided into two parts: I. Practice, II. Theory. In Part I. he gives clear clinical pictures of the common diseases, their pathology, chemistry and physics, their sub-divisions labelled according to their most characteristic signs and their treatment. He begins by taking Pyelitis, and amongst other information he gives details of renal lavage. In no book have we seen such a clear description of the latter valuable treatment, and he gives his reasons why he advocates it so much in his treatment of Chronic Pyelitis. Hee also deals with Prostatic and Bladder conditions, and blood-borne bacterial infections of the Testes. Dr. Panton finishes Part I. with an able description of the Bacteriology of the Urine. This part of the book is invaluable for the practitioner and medical student.

Part II. is given up to theory. Here Kidd criticises the work of Box, Bond and Walker, and here explains in his conception how bacteria reach the kidney. He finishes up with the conclusion that one must not trust so much to pure laboratory research as real clinical research; how it is better and possible to search out by clinical methods the seat and cause of infection, and so to give scientific treatment, i.e., the removal of the cause rather than the palliation of the symptom.

The book is completed by appendices being written on various extra important matters, and there is also a summary of cases which were analysed for the use of the book and which were used as facts for the author's arguments. In addition to being well written, easily readable and understandable, the author has introduced a number of coloured plates which assist in making the book attractive. Kidd's book is well worth reading both for the medical practitioner and the student.

Manual of Hygiene. By John Glaister, M.D., D.P.H. (Camb.) (Messrs. E. & S. Livingstone, 1920); price 10s. 6d.

The author presents a third edition which has been revised. Not many changes from the other editions, however, have been instituted. Two new chapters have been added, one on Vital Statistics which he rightly claims give an interest in the figures relative to life and death, and the other chapter on Eugenics and Bionomics. Here he enlarges on matters referring to growth and development of national life, with its laws, progress and provision.

The derivation of the word Hygiene is taken, and then the author gives an outline how it should be applied to our lives and matters pertaining to them. He points out succinctly but decisively how improvements have been made and on what grounds. Particularly do we like the manner in which his chapters on heat, heat production and its application have been written. He also deals with great skill on the food question and standard diets. On sanitary conditions the most modern methods have been introduced, and here the more difficult parts are elucidated by diagrams—this does not only apply to these chapters, for diagrams are used wherever they could possibly enlighten the reader.

The chapter on vital statistics although clearly written is somewhat complicated, as it entails a fair knowledge of mathematics, and only those who

are deeply interested in such figures, in our opinion, would probe extensively into such facts and figures and their interpretation.

His last chapter on Eugenics and Bionomics begins with an account of Mendel's law and the experiments on which it is based, and how Galton tried to apply such law to human life. The author concludes with a discussion on the sex problem, of the suitability of persons marrying into healthy stock. The book is well written, and for the most part easily read. It is a book which can be read by those who wish to get an insight into Hygiene and Public Health work, or by those who wish to go deeply into the work for the purpose of obtaining a degree such as the Diploma of Public Health.

Notice.

An old Guy's man in practice in a Lancashire town requires a partner—or assistant with a view to partnership—on January 1st, 1921. The practice is a good class one, and affords ample scope for good work, and affords a good income. Only a really good man, keen on his work, and preferably a man who is a graduate, would be considered. For particulars apply in the first instance to X., c/o Editor of GUY'S HOSPITAL GAZETTE.

"Nineties Club."

The Annual Dinner of the "Nineties" Club will be held on Saturday, November 6th, at Oddenino's, Regent Street, at 7.15 p.m. for 7.30 p.m. Dr. Francis Fremantle, M.P., in the chair. As this is the first re-union of the Club since 1914 it is earnestly hoped that as many members as possible may be able to be present.

P. F. HENRY, L.D.S.
LAWRIE McGAVIN, F.R.C.S.
Hon. Secretaries.

Papers by Guy's Men.

A. M. Kempe, L.D.S., "Bournemouth and District Dental Clinic."—*British Dental Journal*, October 1st, 1920.

L. R. Broster, M.A., M.D., O.B.E., "The Medical Aspect of Tanks."—*Jour. R.A.M.C.*, October, 1920, page 308.

F. Shufflebotham, M.A., M.D., M.R.C.P., "The Place of Industrial Medicine in Medical Science."—*Lancet*, October 9th, 1920, page 773.

W. Johnson, M.D., M.R.C.P., "The Acute Confusional States in the Psychoneuroses."—*Jour. Neurology and Psychopathology*, August, 1920.

Drawings of Guy's Hospital.

The following Drawings of Guy's Hospital by Mr. Hanslip Fletcher are now on sale in the Wills Library. Price 5s. each, or £1 17s. 6d. the set of nine:—

Medical Wards and College from Mazepond.
Court Room.
Colonnade.
Gateway and Quadrangle.
Balcony of Martha Ward.
Chapel.
Dental School.
Clinical and Medical Wards from Park.
"Ship & Shovel."

Orders should be addressed to Mr. G. A. R. Winston, The Librarian, Wills Library, Guy's Hospital, S.E.1.

Royal College of Surgeons of England.

MUSEUM DEMONSTRATIONS.

The following demonstrations of specimens in the Museum will be given in the Theatre of the College in Lincoln's Inn Fields.

The demonstrations are open to Advanced Students and Medical Practitioners.

OCTOBER AND NOVEMBER COURSE, 1920.

Fri.	15 Oct.	5 p.m.	Prof. Keith. Specimens illustrating the commoner malformations of the mouth and neck.
Mon.	18 Oct.	5 p.m.	Prof. Shattock. Hypertrophy.
Fri.	22 Oct.	5 p.m.	Prof. Keith. Specimens illustrating various congenital malformations of the Alimentary Canal requiring surgical measures.
Mon.	25 Oct.	5 p.m.	Prof. Shattock. Lipoma.
Fri.	29 Oct.	5 p.m.	Prof. Keith. Malformations of the rectum, anus, vulva, and vagina.
Mon.	1 Nov.	5 p.m.	Prof. Shattock. Fibroma; Chondroma.

S. FORREST COWELL,
Secretary.

Change of Address.

C. G. Coombs, M.R.C.S., L.R.C.P., c/o Dr Cooper, 236, Loop Street, Pietermaritzburg, Natal, South Africa.

St. George B. Delisle Gray, M.B., B.S. (Lond.), British Hospital, Calçada de Monchique, Oporto, Portugal.

E. Gardner Browne, 69, Main Street, Port Elizabeth, Cape Colony.

W. H. Ogilvie, M.Ch., F.R.C.S., 27, Hamilton Terrace, N.W.8. (Tel. Pad. 4085).

Inter-Hospital Cross-Country Cup.

There is still room in the "Spit" for one more Cup, the Inter-Hospital Cross-Country Cup, now held by the London Hospital, and all Guy's men who are anxious to see the Hospital silver collection made as complete as possible are asked to give the following facts their serious consideration. In all the London Hospitals there are probably not more than twelve men who admit that they enjoy cross-country running, and of these at least five are at Guy's. It would seem then that the Cross-Country Cup will be won by that Hospital which has the largest number of men willing to sacrifice themselves for the good of their side. The race, which is from five to seven miles, is one of stamina and determination, and cannot be won by the first two or three who are trained to run the distance, but by the gallant men who run, walk and stumble by turns in their stern endeavours to defeat the walkers and stumblers of other Hospitals. This appeal, we know, will fire the zeal in every one of you. But why not train and make our victory in the race a certainty? At a meeting held on Saturday, 9th inst., at the "Green Man," Blackheath, the following officials were elected for the United Hospitals Hare and Hounds:—President: Dr. H. A. Munro (Guy's); Secretary: Mr. Matthews (Charing Cross); Treasurer: Mr. W. K. Fry (Guy's); Captain: Mr. L. G. Housden (Guy's); after which election the meeting was adjourned until next Thursday, 21st inst., at the Charing Cross Hospital at 5 p.m. A notice will be posted in the Colonnade next week, and Guy's men are asked to turn up in strength to fix such important items as the date, place and distance of the race for the Cross-Country Cup.

Hockey.

The 1920-21 season opened auspiciously on Saturday, October 9th, when the First and Second XI.s met the First and Second XI.s of the City of London Hockey Club at home and away respectively; the First winning by 7 goals to 3, and the Second by 8 goals to 2.

At home the play was individually good, though the team lacked combination at times. The attack, however, was strong, and the defence sound, the game concluding as above, Tonkin scoring 3, Schollum 2, and Bonnalie 2.

Away the same story seems to have been told—some lack of combination but good individual work. Eglington contributed 5, Smallbone 2, and Spurrell the remaining goal, and the final score gives an excellent idea of the game. Shepherd proved very valuable at centre half, and the team as a whole shows great promise.

Guy's Hospital Cricket Club.

At a meeting of "Blues" on September 30th, T. Wooldridge was elected Captain of Cricket for 1921.

At the Annual General Meeting of the Cricket Club the following officers for 1921 were elected:—

President.—C. H. Fagge, Esq.

Hon. Sec. and Treas.—L. C. Willis.

Vice-Captain.—L. B. Helder.

Committee.—J. Van Schalkwijk, J. D. S. Thomas, G. D. Shaw, and F. J. Biddle.

Football.

GUY'S v. LONDON IRISH.

It is always unsatisfactory to set about an opponent short of his full fighting strength, and for this reason there was not very much fun in beating a weak side of the above Club at Honor Oak Park on October 11th by 10 goals and 6 tries (or 68 points) to nil. The team opposed had had to find substitutes, not up to First XV. standard, and arrived one short. These fourteen did all they could, but for most of the second half they were further depleted, as Anderson, their full-back, got crocked.

There was another large crowd when play commenced, and they soon got their money's worth as far as Guy's scoring was concerned. The whole XV. were on their toes, and play proceeded at a great pace. Taylor and Neser were playing instead of Doherty and Shelswell, and Graham-Davies was on the wing to C. L. Steyn. Very soon Steyn showed signs of injury, but whatever the strain was, it did not become serious, as he ran and played with great dash. The first to score was Graham-Davies. The long kick was not successful. Soon after the drop out, the ball was constantly with the Guy's backs, who ran and passed at such a rate that the Irish defence became literally tied up. Much of the passing was most beautifully timed, J. A. Krige's play being a model in this respect. Albertyn benefited greatly, and he put on a couple of tries and Steyn a like amount very quickly. Van Schalkwijk placed three goals, and soon after added a fourth from a try secured by Steyn, who ran practically from his own goal post, Graham-Davies backing up splendidly until Steyn had cleared his field. Biddle next went in; he took the pass well before going in by the upright. Van Schalkwijk had no difficulty in goaling. In the corner Bekker scored in characteristic fashion. Reitz made a good shot from long range. J. A. Krige put Albertyn

in again just before half-time, when Guy's were leading by the comfortable margin of 37 to nil.

The one-sidedness of the game continued, and only for a very brief period were we out of their 25. Tries soon began to pour in, Steyn getting a fine try. Then came an excellent movement by Neser, who sent Krige away to score after a long run. Van Zyl was the next to get three points. A second long run and pass by Krige led to Albertyn again going over the line. Marais, who had been conspicuous by some good open work, crowned the strong movement of the Guy's pack by crossing the Irish line and running to the posts. Albertyn had yet another try to his credit, making his score level with Steyn, 5 each. The recital is finished by recording a final try from Graham-Davies, who only just previously had seemed a certain scorer when the ball slipped from his hands. Van Schalkwijk brought his total of goals to nine, and the match ended as stated above. The match gave the Hospital team some fine running and passing practice. The forwards were very good indeed, and the backs took full advantage of the poor defence facing them. T. A. Shaw had very little to do, but the few opportunities he got were well made use of. Guy's team:—

T. A. Shaw, P. K. Albertyn, J. A. Krige, C. L. Steyn, H. Graham-Davies, F. Bekker, J. G. Van Schalkwijk, F. W. Reitz, E. E. Neser, H. Van Zyl, C. Marais, F. J. Biddle, C. Macintosh, R. F. H. Duncan, and H. J. Taylor.

GUY'S "A" v. SOUTHEND.

On the 2nd September our "A" XV. went down to Southend to play the opening game of the season. The weather was ideal, and the ground in good condition. As the machinery of our back line still needed some oiling, we did not shape too well, and were, in fact, outclassed in that department. The struggle rested mostly with the forwards, and of the two packs ours was, if anything, the better. Perhaps there was not enough foot-work amongst our forwards. In fact, for the first time in our memory, our opponents complained that Guy's did not give them enough of the boot! Consequently the game was marked throughout by being exceptionally clean, though a very hard one. Shortly after the start our opponents gained a rather doubtful try, which they failed to convert. J. S. Jacobs shaped very well at full-back, and by his exceptionally long, touch-kicks right through the game we managed time and again to invade their territory. But we lacked the necessary finish, and could not succeed in crossing the line, until just before half-time H. K. Williams scored our first try. The whistle went with each side having three points to its credit.

On the resumption we had to play uphill (*some* hill indeed!). We fought hard, but could not prevent their gaining two more tries in quick succession—one of which was a mere fluke. They failed to convert these. Our forwards now made a heroic attempt, and a good rush ended in Watson dribbling across and scoring a very fine try. Shortly after this Southend gained another try, but failed to add the major points. Guy's was once more on the attack, but the finish came when we had forced them to their twenty-five, with the score Southend 4 tries (12 points) to Guy's 2 tries (6 points). The following represented Guy's "A":—

J. S. Jacobs, L. Weinberg, T. A. Shaw (captain), E. C. Seward, H. K. Williams, W. J. Walters, S. P. Meacock, L. K. Watson, G. Zondagh, P. E. Harvey, G. R. D. Bradfield, W. H. Close, J. H. Currie, G. Stoker, and A. Jeans.

GUY'S "A" v. OLD ELTHAMIANS.

Played on the Eltham College ground, October 9th. Guy's "A" started with fourteen men. Jeans was taken out of the pack to fill the full-back position. Guy's pressed from the start, and were awarded a penalty, which was well placed by Harvey. Soon after Weinberg dropped a neat goal; half-time arriving with the score 7 points to nil in Guy's favour.

On the resumption Seward arrived and completed the team, Jeans returning to the pack. The Old Elthamians scored in the corner from a line out, and later Weinberg scored for Guy's from a reverse pass by Williams. Berry did well in an unaccustomed position, but his centres must follow more closely. The marking and tackling by our opponents was extremely keen, and should have taught our forwards a lesson—at present they are far too prone to straggle, they must keep together. Result: Guy's "A" 10 points, Old Elthamians 3 points. Guy's team:—

E. C. Seward, G. H. Gough, L. Weinberg, H. Van Harden, H. K. Williams, S. P. Meacock, W. Berry, L. K. Watson, G. Zondagh, L. B. Helder, P. Harvey, G. R. D. Bradfield, —. Mackenzie, H. Jeans, and F. G. Hutchinson.

GUY'S v. BLACKHEATH.

A grand day, a grand game, and a grand gate. Such can be recorded of October 2nd, when in the presence of 5,000 spectators Guy's were defeated by a solitary try to nil at Honor Oak Park. Indeed, the time has arrived to enlarge the covered seating accommodation; in fact, after Saturday, the matter is slightly overdue. Never before has it been necessary to warn the crowd waiting their turn at the gates that the ground was full and a fair view almost unobtainable. But this had to be done on the day under notice, so packed were the boards surrounding the field of play. The new stands soon filled, the covered stand and seats behind the goal posts also. Most enthusiastic were the spectators, and one must differ with a writer in a contemporary which stated on Monday that it was "the Club" more than Guy's who caused the match to be voted an uncommon success. By "the Club" it must mean the Blackheath Club and followers. I beg to state that on Saturday, October 2nd, it was neither the Club nor Guy's but the fact that both were at Honor Oak Park, that both are jolly good sides, and that a hard and splendid match was likely. This was the prospect that made the afternoon such a success.

Very punctually the sides turned out, and at once it was seen that P. K. Albertyn had taken the place on the left wing instead of Reitz, who went to his usual place among the forwards. Quite early it was apparent Van Schalkwijk was not taking his passes well. The home forwards were well on the ball, and Cumberlege had his first visit from Doherty and his splendid pack. A couple of rounds of passing ended with Albertyn kicking dead and though the forwards on both sides were doing well it appeared that both sets of backs were obsessed with that touch-finding business which prevailed so pointedly in last year's final. Magnificently Doherty led his men, and every one of the seven responded nobly. A wee bit more determination behind and the first half would not have been pointless. Just before half-time we had a very narrow escape, some good Blackheath passing ended in Lowe kicking across, and Van der Rilt almost got the touch.

Resuming, Horan got his men on the move, but Cook broke up the movement by missing the pass. However, it was not long before Krige dropped at goal. Unfortunately, it hit a Blackheath man, and play was transferred to the other end, where Steyn and Olivier had bad luck with the bounce from a lofty kick. Horan, being well up, secured and got a try. Coverdale essayed a kick for the extra points without success. Bekker, who has never played better, was now sending the ball out cleanly from our untiring pack, but it was not "our day out" among the backs. The ball was not handled so well as usual, and all the time Blackheath were very strongly defending. Both Doherty and Krige nearly got over the line. Give and take play followed, but if Blackheath got near Olivier he sent them back with some fine touch-finders. Very strenuous efforts were made to equalise as time approached. Steyn made a run or two, and Albertyn found Lowe difficult to shake off. Just before the end Cumberlege tackled Steyn, who was brought up only just short of the line, the final score being Blackheath, 1 try (3 points); Guy's, nil.

Guy's team:—W. Olivier, C. L. Steyn, H. Graham-Davies, J. A. Krige, P. K. Albertyn, J. G. Van Schalkwijk, F. Bekker, W. D. Doherty, F. W. Reitz, A. H. Shelswell, R. F. H. Duncan, C. Marais, H. Van Zyl, F. J. Biddle, C. Macintosh.

The forwards played very finely indeed. No one should be mentioned specially except Doherty, who was in top form. The backs did not appear so happy as usual. Bekker was perfectly sound, and so was Olivier. Van Schalkwijk had hard luck in finding himself not quite up to concert pitch. The line behind him will, with a little more practice, be doubtless quite up to, if not beyond, last year's form. One must remember that the Blackheath tackling and general defence was of a very high quality.

GUY'S HOSPITAL v. EMERITI.

The Soccer Club opened their season with the above fixture at Honor Oak Park on September 2nd, 1920. Our forward line was of a more or less experimental order, but by no means disgraced itself. At the commencement play settled down in mid-field. Gradually our forwards showed their superiority, and caused the Emeriti defence many anxious moments. After twenty minutes play Trott opened the scoring as the result of a fine solo effort, beating the goalkeeper with a high shot. Our goal was next in danger owing to a miskick by our defence. Following a fine run by the forwards, Froehlich scored.

In the second half both teams slowed down considerably, and play was for the most part confined to mid-field. There was no scoring in this half. Guy's team:—M. H. MacKeith, C. A. Wakeford, D. E. C. Robertson, F. L. Rayner, D. H. Couch, E. B. Corry, B. Crisp, L. Froehlich, R. G. Pengelly, L. A. S. Trott, and J. C. Hewetson.

Specialities.

"BRONAMALT."

Malt extract in many forms has been prepared as a good Tonic Food, and there are undoubtedly several which serve this purpose, but Bronamalt, which is a liquid Malt Preparation containing the hydrobronic acid extractives of cinchona bark, may rank as one of the most serviceable of these preparations obtainable.

In cases of debility, malnutrition, &c., it may be prescribed with advantage, and also can be safely recommended as a real Tonic Food for women after confinements and during the period of lactation, or for patients convalescing. It is a bright amber coloured preparation, and has the advantage of being both pleasant in taste and free from odour.

Marriages.

CROOK-PERRY.—On the 30th September, 1920, at the Church of Holy Trinity, Kensington Gore, by the Rev. H. B. Coward, Francis William Crook, youngest son of Mr. and Mrs. S. B. Crook, of Shanklin, I.O.W., to Mary Catherine Perry, only daughter of Sir Cooper and Lady Perry, of Kensington Gore, London.

GRAY-STANTON.—On the 9th October, at the Church of St. Mary of the Angels, Westmoreland Road, W., by the Rev. Paul Napier Hemy, St. George Bernard Delisle Gray, M.B., B.S. (Lond.), elder son of Dr. and Mrs. St. George Gray, of 9, Drayton Gardens, S.W.10, to Geneviève Celia (Viva) Stanton, youngest daughter of Mr. and Mrs. W. H. S. Stanton, late of Blackheath.

PRITCHARD-McALPIN.—On the 9th October, at the Presbyterian Church, Putney, by the Rev. J. Cockrane, M.A., assisted by the Rev. C. Anderson Scott, D.D., George Brentnall Pritchard to Isobel Emmeline McAlpin, only daughter of Mr. and Mrs. Kenneth McAlpin of 47, Hazelwell Road, Putney.

Ed.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT a recent meeting of the Guy's Hospital War Memorial Committee the final arrangements with regard to the erection of the Memorial were made and the work will very shortly be started.

As the Fund was started two years ago when many Guy's men, past and present, were away at the War, and consequently out of touch with the affairs of the Hospital, it may be well to give a brief review of the history of the War Memorial from the beginning.

The first Appeal was sent out in November, 1918, and four alternative schemes were proposed. These were—

(a) A Memorial to record the names of Guy's Medical and Dental men who had fallen in the War, to be placed within the precincts of the Hospital.

(b) A Fund to enable the sons of Guy's men, who had fallen or suffered by the War, to receive free or assisted education at the Medical or Dental Schools of the Hospital.

(c) A Fund to enable daughters or widows of Guy's men, who had fallen or suffered by the the War, to receive a free or assisted education in those departments of the Hospital which were open to Women.

(d) An Endowment Fund for Entrance Scholarships to be open, in the first place, to the sons of old Guy's men.

Subscribers were asked to fill in a form indicating their order of preference for these four alternatives. The votes were allotted on the principle of the "transferable vote," with the result that scheme (a) received 578 votes, (b) 683 votes, (c) 480 votes, and (d) 294 votes.

In the following June a further circular was issued. In this it was pointed out that the widows and orphans of fallen Guy's men were very few in number and that not many Guy's men had been disabled. Bearing this in mind, and also considering the activities of the Royal Army Medical Corps Auxiliary Fund, the Committee felt that there would be little need of money for the original scheme (b), which had secured the largest number of votes in the initial ballot. They, therefore, made three further suggestions. First, that some of the money be devoted to building the new Clinical Ward in which should be inscribed the names of the fallen men; secondly, that the College Dining Hall should be redecorated, the decorations to include memorial panels bearing the names; and thirdly, that a sum should be allocated for the endowment of a Dental Research Scholarship. A general meeting was called for October, 1919.

At this general meeting of subscribers it was decided to dispose of the total, £5,300, as follows :—£2,000 for a permanent memorial to be erected in the Park; £1,000 for the assistance, if necessary, of the families of Guy's men who had fallen in the War; £2,000 for the endowment of Scholarships, preferably for the sons of Guy's men; and £300 for the adornment of the College. In addition to this, the Medical School decided to give a Senior Science War Memorial Scholarship as a contribution to the War Memorial Fund.

The Committee have carefully considered the form that the permanent memorial, to be erected in the Park, should take. At a meeting held last week it was decided to erect a Memorial Arch, which has been designed by Mr. Walford, the Hospital Architect. This arch, which is of extremely simple design, but of very graceful proportions, is to take the place of the gate and railings at present facing on to Maze Pond. The whole structure, which is to be of stone, will reach from the south-east corner of Astley Cooper Ward to the north end of Hunt's House. Inside, on the two central columns, will be inscribed the names of the Guy's men who fell in the war. Above, on the inside, will be inscribed the words, "In Memory of Guy's Men, recorded hereon, who lost their lives in the Great War, 1914—1919." In a similar position on the outside the inscription is to be "Erected by the Friends of 110 Guy's Men who lost their lives in the Great War, 1914—1919."

These inscriptions would, no doubt, be open to revision, and we feel sure that the Committee would welcome any suggestion for their alteration or improvement. The estimated cost is £1,960. We hope to be able to include in our next issue a picture of the Memorial Arch with a more detailed account than it has been possible to give here.

A month ago we mentioned the fact that the War Office had decided to re-establish the Medical Units of the University of London Officers' Training Corps. In this number of the Gazette will be found a letter from Mr. Layton (or rather Major Layton, D.S.O.) announcing his intention of restarting the Guy's Unit, and giving both his reasons for doing so and the methods by which he proposes to accomplish it. A notice containing very full details of all that is involved in membership of the O.T.C. will be found on pages 381-388.

We should like to associate ourselves very heartily with all that Mr. Layton says in his letter, and we hope that the trouble that he has always taken, and is still taking, with the Hospital O.T.C. will be rewarded by the enrolment of large numbers of students. There is no lack of enthusiasm for the Special Constabulary, and the O.T.C. should provide much more interesting work if Mr. Layton's admirable programme receives the support that it deserves.

But quite apart from the general interest of the scheme, there are other considerations which should recommend themselves to the medical student. As we have pointed out before, training in military medical work is a training which is of far-reaching value. The medical and indeed the administrative officers of the Royal Army Medical Corps are concerned with training a large number of men up to a high standard of health and hygienic environment. This is an aspect of medical art which receives little or no attention in the medical curriculum. The civilian doctor is regarded primarily as a curer of disease. In fact, he has a direct financial interest in the incidence of disease rather than in the incidence of health. The position has been somewhat modified by the Insurance Act, and there is an increasing tendency both on behalf of the profession and

the general public, to lay stress on the importance of Preventive Medicine. To those who have no intention of entering the Services as a profession, the course of instruction suggested for the Guy's O.T.C. Unit should be of great value. Here and nowhere else they can learn those principles of Preventive Medicine which, of extreme importance in military work, are surely no less important in civil practice.

The opportunities for research in several vital but disputed questions of military hygiene, mentioned in the last paragraph of the notice dealing with the O.T.C., adds an intellectual interest which should have a wide appeal.

We understand, further, that Mr. Layton has secured promises from a number of distinguished combatant officers to come to the Hospital and talk about medical work from their point of view. In addition to this, many eminent young specialists, who have had special opportunities during the war of studying various aspects of medicine and surgery, have consented to give instruction on such conditions as gas, gas gangrene, shock, trench fever, D.A.H., and other diseases which war brings into especial prominence. These lectures or classes, which will be quite informal, will all count as parades. Such drill as must be done will be left for camp, and even there reduced to the bare minimum.

It is possibly not generally known, at any rate to the present generation of students, that the Guy's Hospital Reports are, along with many another of the old Hospital Institutions, at present under process of reconstruction. Instead of being published annually by the Gazette, as previously, the Reports are now to be issued quarterly and the annual subscription is to be two guineas. To ensure the financial success of the first year of this new arrangement, a guarantee of subscriptions amounting to at least £400 is required. So far promises for £350 only have been secured. The Editor, Dr. Hurst, asks us to bring this matter to the notice of our readers so that any old Guy's men who have not yet promised to subscribe may be reminded before it is too late. It is also possible that some of the more senior students and recently (or shortly-to-be) qualified men would like to subscribe to the first year's issue. Promises of two guineas for the first year of the new Reports does not involve any obligation to continue as a subscriber. Will all those who want the Reports let Dr. Hurst know as soon as possible? The Reports will be divided into sections (Ophthalmology, Laryngology, etc.), each under a separate sub-editor. The result should prove to be a medical journal unequalled in the English language.

The issue of membership cards to members of the Clubs' Union was mentioned recently in the Students' Number, but apparently it has escaped the notice of some old Guy's men. For their benefit we would repeat that these cards are now issued to all subscribing and life members of the Clubs' Union, and that they can be had on application to the Medical School Office. The possessor of a card, and no other, is entitled to the privileges of membership of the Clubs' Union. As these privileges include free admission to the Ground at Honor Oak Park for football matches, it is important that intending spectators who are either subscribing or life members should make early application for their cards of membership.

A most excellent Demonstration was given at Lambeth Infirmary on Tuesday, October 19th. Nearly forty men from the Hospital attended, ranging from first three months' medi-

cal ward clerks to members of the Staff. In spite of the crowd everyone was able to see the patients clearly, as they were all collected into one ward. Notes of the cases will, if space permits, be included in the next issue of the Gazette. There is no need to urge those who failed to go to make a point of attending the next one to be held on December 7th, for they cannot fail to be impressed by the immense enthusiasm of those who went. All concerned will wish us to express our thanks to Dr. Stebbing for the excellence and thoroughness with which preparation had been made, and even more for his admirable and lucid exposition of the special features of each case. If we have any complaint to make at all it is that we have to wait so long for the next.

Case for Commentary.

Suggestion. Anaphylaxis from diet. Last attack —mackerel?

17th October, 1920. F.E.

In the report of this interesting case no mention is made of the patient's diet. To me it appears that the explanation may be some dietetic idiosyncrasy, the case being closely paralleled by one that recently came under my observation. In my case the diagnosis was suggested to me by the patient herself, whom I found in a state of collapse following temporary unconsciousness with moderate pyrexia and intense dyspnœa, conjunctival congestion and a widely distributed patchy erythema. She told me that she felt as though she had been poisoned by eating honey, having had similar attacks earlier in her life after eating honey, but she was sure that she had eaten none recently. Subsequent enquiries elicited the fact that owing to war time sugar shortage some food she had partaken of had been sweetened with honey. Was it possible in Dr. Allen's case that his patient had at long intervals happened to eat or drink something to which he was hypersensitive, and that his attack was similar to anaphylactic shock in other forms of hypersensitiveness.

19th October, 1920. G. H. PENNELL.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Mr. Editor,—May I associate myself with the concern expressed by Major C. H. Reinhold, I.M.S., at the suppression of the Annual Garden Party.

As you are careful to point out, the Prize Giving is a function essentially for the students, and no one need regret its divorce from the Garden Party. I venture to believe, however, that it was the latter function which made such a wide appeal to Staff, students, and Nursing staff—in fact, to all who were in any way connected with the Hospital; and from an old Guy's man's point of view its disappearance is much to be regretted. In a lesser degree it provided that opportunity for "reunion" in the summer, which Christmas at Guy's always supplied in the winter.

When we old Guy's men do return from the Colonies or the Tropics, our visit to the Old Country is more likely to take place in the summer than in the winter; and as regards the Services, we of the I.M.S. undoubtedly have far fewer opportunities of visiting our Alma Mater than our brother officers of the R.A.M.C. and Royal Naval Medical Service. After nine hot weathers in the East I am looking forward to spending the summer of 1921 in England, and shall still hope to find the Garden Party at Guy's resuscitated.—Believe me, Sir, Yours very truly,

E. A. PENNY,
Major, I.M.S.

4, R.A. Lines,
Meerut, U.P., India.
24th September, 1920.

Change of Address.

E. Reynolds Ray from 52, Brook Street, to 4, Coventry Chambers, 35, Haymarket, S.W.1.

Sir Charters J. Symonds, K.B.E., C.B., C.M.G., M.S., M.D., F.R.C.S., only address 58, Portland Place, W.1. ('Phone Padd. 345).

Appointment.

N. Mutch, M.D., F.R.C.P., to be Consulting Physician to the American Red Cross in England.

Head Injuries.

NOTES OF A CLINICAL LECTURE BY MR. BROMLEY.

The diagnosis of head injuries is rendered extremely difficult owing to the complicated nature of such injuries. A blow on the head may produce a simple contusion, or it may be complicated by a fracture of the cranium and further complicated by laceration of the brain or other intracranial complication.

Individually, perhaps, each injury may be regarded as having its own particular symptoms and signs and be easy to diagnose, but collectively a complex group of symptoms and signs presents. In head cases one is not often able to obtain a reliable history of the injury, and little assistance is given by the patient in eliciting symptoms and signs.

The inspection of a case of head injury leads one to a consideration of the scalp.

The scalp may be considered to consist of two layers :—

1. The epicranial muscle and its aponeurosis, together with the tissues which lie superficial to it, and with which they move; these are : (a) the subcutaneous tissue, which consists of a dense fibrous framework supporting a considerable number of blood vessels; and (b) the covering skin.

Injuries which involve this layer lead only to a localised hæmatoma at the point of injury or to profuse hæmorrhage if the skin is broken.

Superficial and localised sepsis is a complication frequently met with; and further, the connections of the blood vessels in this vascular region provide a path by which blood stream infection originating from a superficial wound may spread to within the cranium, by means of emissary veins which pass through the cranium and connect with the intracranial sinuses.

One's early treatment of such a case must be directed towards obviating the possibility of these sequelæ by thorough cleansing of the scalp, which includes shaving over a wide area. As a practical point, examination of what appears to be a simple scalp wound should never be undertaken until this cleansing and shaving has been completed.

2. The second layer of the scalp is of a different character, and is in the nature of a space lying between the epicranial muscle with its aponeurosis and the pericranium. This space is filled with loose areolar tissue, and it is by virtue of this loosely packed space that the scalp moves on the vertex. The space is limited by the attachments of its superficial structure, the occipito-frontalis muscle with its aponeurotic extensions; these are, in front, the superciliary ridges, behind, the highest curved line, and on each side, the zygoma.

Injuries which penetrate to this layer may produce widespread effects; a hæmatoma, which may subsequently suppurate, is free to spread within the limits of the attachments of the muscle and aponeurosis. Suppuration within this layer is liable to affect the pericranium and bone, and by means of emissary vessels through the bone, lead to generalised infection.

Treatment, as in the case of the more superficial wounds, must be directed towards guarding against possible infection; and where a collection of blood has occurred, evacuation by aspiration or incision is necessary. Suppurative collections require multiple incisions at their most dependent points and the provision of adequate drainage.

Underlying the scalp is the cranium, the bone consisting of an outer and an inner table separated by the diploe.

The pericranium covers the outer table and is firmly attached at the sutures between the bones; the equivalent lining to the inner table is the dura mater, which, however, is not so firmly attached.

The pericranium may be raised from the bone by extravasation of blood; this condition is liable to occur in the new-born in cases of difficult labour, and the extravasation is limited by the attachment of the pericranium at the sutures. This is the condition known as cephalhæmatoma. The blood generally absorbs without further complication, but in some cases aspiration is advisable.

An injury may lead to contusion of the cranium without actual fracture, and, unless complicated by sepsis, such an injury is only important in so far as it may be associated with cerebral injury. If, however, sepsis supervenes, a variety of conditions may occur, the result of sepsis in the various planes of structures between the pericranium and the brain, namely :—

1. Subpericranial abscess.

2. Diploe infection, leading to necrosis of the outer table, with possible septicæmia and pyæmia.

3. Extra dural suppuration, with which is associated the sign known as Pott's puffy tumour.

4. Chronic inflammatory thickening of bone and dura.

5. Cerebral abscess.

Fractures of the cranium are usually classified as those of the vault and those of the base; however, frequently a fracture will be continuous from base to vault and *vice versa*. The more localised fractures of the vault are those resulting from direct contact with sharp objects.

The base of the cranium is seldom fractured in this way except in the case of perforations through the roof of the orbit and through the nose.

Clinically, fractures of the vault may be subdivided into :—1. Those without displacement of bone; and 2. Those with displacement. The importance of fractures without displacement lies in the fact that an injury sufficient to produce such a condition will no doubt have a severe effect on the brain; and there is, in addition, the possibility of the rupture of the meningeal vessels which lie either in tunnels in the inner table or between the inner table and the dura. Fractures with displacement of bone are either elevated, the so-called sabre-wound fracture, or depressed.

The depressed fracture is, in every case, a severe condition, and it is more liable to produce an effect on the brain and to cause rupture of meningeal vessels. In addition it usually implies tearing of the dura, leading to subdural complications with laceration of the brain.

It must be remembered that a depression of the inner table alone may occur, the surface of the cranium presenting no marked deformity.

The prognosis in cases of fracture is extremely bad and depends on the extent of the associated injury to the brain.

In cases of recovery, remote effects in the form of persistent headache, epilepsy, or insanity may be produced.

Treatment is directed towards producing complete rest for the brain by a reduction of all possible stimuli; the immediate complication, that of sepsis, is obviated as far as possible by aseptic and antiseptic treatment.

In all cases of depressed fracture open operation is essential with a view to elevation of the depressed fragments or their removal. This is as important for the relief of the immediate effects as it is for guarding against permanent after effects.

Fractures of the base of the cranium may occur through a blow on the vault in the following ways :—

1. A continuation of a fissure fracture of the vault.

2. A compression in the region of the blow which brings about a bulging in another region; the bone may break at eitehr the compressed or bulged parts.

3. Vibrations which originate at the point of impact travel round and meet at the base where, as a result, fracture occurs.

4. By means of a blow on one part of the head, an opposite part may be driven against a hard object causing fracture.

The base may be fractured indirectly by a fall on the feet or buttocks, the violence being transmitted through the vertebral column to the occipital bone. Further, a blow on the jaw may produce fracture of the base, the force being transmitted through the ascending ramus and condyle.

From the point of view of its interior, the base of the cranium is subdivided into anterior, middle, and posterior fossæ; fractures, however, are not often limited to one fossa.

The signs of fractured base are extremely variable. In the first place, there may be none; secondly, there may be signs only of the associated cerebral lesion.

In some cases, however, definite signs are present. These may be grouped as follows:—

1. Escape of blood, cerebro-spinal fluid or brain substance from
   - (a) Ear.
   - (b) Mouth.
   - (c) Nose.
2. Hæmorrhages:
   - (a) Suboccipital.
   - (b) Mastoid.
   - (c) Subconjunctival.
3. Injuries to cranial nerves.

Bleeding from the ear, provided it is not from a superficial lesion, indicates a fracture through the petrous portion of the temporal

bone, involving, probably, both the posterior and middle fossæ.

Bleeding from the mouth, if not a regurgitation of swallowed blood, indicates fracture in the region of the body of the sphenoid in the middle fossa, while that from the nose indicates fracture involving the cribriform plate of the ethmoid in the anterior fossa.

The subconjunctival hæmorrhage is of late appearance (second or third day) and extends from below and on the outer side towards the centre, becoming cone-shaped. It occurs as the result of the gravitation of extravasated blood in fractures of the roof of the orbit.

Where cranial nerves are injured, the evidence is supplied most readily by the motor nerves, which are as follows:—

III., supplying ocular muscles.
IV., supplying superior oblique.
VI., supplying external rectus.
VII., supplying facial muscles.
XI., supplying sterno-mastoid and trapezius.
XII., supplying tongue muscles.

The effects on the parts supplied by an injured nerve are, firstly, spasm; secondly, loss of function; and thirdly, paralysis.

The treatment of a case of fractured base is, as in other head injuries, rest by means of reduced cerebral stimuli and attention to possible infection through the channels of the ear, mouth, and nose.

Some Stories.

Seven years since you published a short account of my experiences during the foregoing twenty years. The last few years have provided me with some strange cases that I will now shortly repeat and finish up with a few warnings and hints.

Mrs. M., 37, was delivered after an hour's hard work, with forceps, of her second baby, a fine child. In the following night she had severe afterpains, passed two scraps of amnion and was considerably relieved. Temperature next morning was 99°, and pulse a little faster than usual; the abdomen was very tender. In the evening there was much painful distension. Temp. 102°. Next day still pain and tenderness with distension. Temp. 98·4° and slight emesis; at night great pain and flatulence; a turpentine enema much relieved her. On the third night she was quiet, but hardly slept at all. In the morning when I called the nurse reported that she had been "very ill" at 4 a.m., and I found her vomiting and apparently dying. With pituitrin and other remedies and a copious enema she greatly improved. Pulse was very fast, 120; temp. 98·6°. At 2 p.m. pulse was 130, full and good; she talked of the events of the day. At 6 p.m. she was desperately ill, but quite conscious. Dr. Drummond-Robinson examined her and found all normal. At 5 p.m. her baby, who had been comatose for some hours, died. Her pulse began to race and at 9 p.m. she died. The distension was less marked than it had been. Her urine was normal.

No post-mortem was possible. Placental toxæmia has recently been advanced as an explanation of such excessively rare cases.

Mrs. L., 35, went through a normal second gestation, and was easily delivered with forceps of a fine nine-pound baby in the afternoon. At 4.30 a.m. nurse came to me as she was in great pain. I found her groaning with the most severe afterpains, and gave her an I.M.H. At 9 a.m. pain was worse and the pulse hurrying; temp. 102°. There was little distension. At 11 a.m. I decided that she must be "investigated," and removed her to Richmond Hospital, where Mr. Heekes opened her abdomen and found loose pus—and both her ovaries large, acutely inflamed organs, her tubes also inflamed and œdematous. She died in twenty-four hours. The woman had passed through a normal gestation with these inflamed organs; how long they had been so it was impossible to say; and they only infected her peritoneum at the parturition.

Mrs. S., 40, was delivered of her second baby quite easily with forceps. There was slight post-partum hæmorrhage. She did not look well, and I found her pulse 116. In five minutes she nearly died. She soon recovered somewhat, and when I left her she was very ill, but out of danger. Next morning her temp. was 102° and she looked very ill indeed; pulse 120. For days her temperature was raised and her pulse rapid, and she passed through two more attacks of severe heart failure. My partner, who had charge whilst I was away, found that her heart was dilated; nothing was ever discovered amiss of any other kind. When I returned after a month she was still very ill and feeble,

but the heart was normal in size. What the explanation was I know not.

Mrs. P., æt. 25, was delivered with forceps of her first baby with some difficulty. In twenty-four hours her temperature was 102°. For three weeks the temperature, which varied to as much as 104° in the morning and often fell to 101·5° in the evening. At ten days there was some discharge from the vagina with œdema of the labia; this was cured in three days with constant injections of lysol and water. She had some erythema about the buttocks. Every other organ was healthy. She suckled her baby and looked and felt well and ate heartily. At the end of three weeks the baby had some erythema on the arms, sickened one day and died the next. The mother developed acute erythema with vesiculation of both feet and the last few inches of the legs. When this occurred her temperature fell to normal! It can hardly have been due to a septic infection, as her temperature was raised so early, and throughout was higher in the morning than the evening. Frankly, I cannot explain it.

Mrs. P., æt. 42, while on a holiday in the country developed a mild tonsillitis on Friday; on Sunday she was quite well, on Monday afternoon she felt ill and her temperature was 102°. She was sent to bed; two days later, for over thirty-six hours, morning and evening, her temperature was 104°. Two days later she developed desperate pain in her right tarso-metatarsal articulation, with two little red patches over it. Temperature was now 102°, morning and evening. Then a few very painful erythemata on both forearms. Four or five days later she complained of pain in the left knee. In three or four days this became acutely painful and the synovitis was severe, and the whole leg began to swell. On a splint during the next week the pain was less and the synovitis diminished, but the swelling of the leg and the thickening of the femur increased. The temperature was now 98·4° in the morning and generally 100° in the evening. At the end of three weeks from the onset the temperature rose again to 102° at night, but locally there was diminution of the swelling. The temperature fell again, and she returned to London in a motor car. On the third day the surgeon, Mr. Webb Johnson, decided to puncture; a quarter of an hour before doing so, the temperature was sub-normal. Three ounces of pus were withdrawn which gave a pure streptococcus culture! She has progressed fairly well since, with great pain, her temperature very rarely above 99°, and the discharge very slight, *i.e.*, a streptococcal abscess in the knee-joint with a sub-normal temperature.

A little girl of five had a severe attack of asthma. As I had been taught at Guy's, I told the father, "Asthma never kills." In ten hours she died of apparently acute capillary bronchitis. The father has never forgiven me.

A woman of 50 had very severe Bright's disease—"large white woman, large white kidney." On two occasions she very nearly died of desperate attacks of uræmia. For two years she was very ill; now she is perfectly well, with no albumen, and has been for a year past. This, I am told, is very rare, but is known to occur.

A young Norwegian woman had a baby. Three months later I excised half her right breast for what appeared to be typical chronic mastitis. The pathologists reported the tumour to be a virulent carcinoma. Complete removal.

A woman of 40 had rectal pain with some hæmorrhage. I examined and found a polypus, as I expected; this I excised. It had a wider base than was normal for a polypus and a fungoid-like surface. It was cancer. Excision of the rectum very nearly killed her, and she was desperately ill for two months. When last I called at the house I found her cleaning up the stairs with a mop!

A handsome young woman, æt. 30, was suddenly attacked one night with headache. Next morning she was found to have definite right hemiplegia with loss of voice. As there was an old history of Bright's disease I naturally attributed it to that cause. Urine was normal. From the symptoms and the optic neuritis, which was transitory, cerebral tumour was confidently diagnosed by two consultants. I met her a year and a half later; she had returned almost to the normal, only her voice was slightly affected. It was not cerebral tumour—what was the cause?

A lad of thirteen wished to join the Worcesters. I found that he had five dioptres of myopia of which neither he nor his parents had the least idea. He was able to read at 10 inches and enjoyed the theatre.

A man of 36, after an attack of syphilis ten years ago, had a tertiary ulceration which glued

his palate to his naso-pharynx and caused total nasal obstruction. I released the palate with some difficulty. As the individual was restless, rather less than half a grain of morphia (subsequently proved to be so) was given hypodermically. Five hours later he died of morphia poisoning. This experience is, I learn from wide enquiry, fortunately unique.

An infant of six weeks was severely scalded about the buttocks with cloths washed with a well-known soap. General practitioners will know its name from painful experience. Three days later it died.

A man, æt. 55, had severe albuminuria secondary to a very large prostate. This was removed by an expert surgeon. He has never recovered the use of his urethra in spite of various attempts to restore it to service again. It is now three years since the interference. He wears an abdominal apparatus, continues his work, and is well and fairly happy. This is very rare, but it is not unknown.

A man, æt. 60. Three years ago I did a posterior gastro-enterostomy for him, as he had a typical history of duodenal ulcer for the last twenty-four years. We could not feel an ulcer. For two years there was considerable improvement, but not cure. Now, at the end of the third year, he is a healthy, happy man.

Some hints and some warnings from my experience may be of value :—

Large doses—very large doses—of arsenic will hold pernicious anæmia in check for years.

Hypodermic doses of five to seven drops of adrenalin (1—1000) will cure attacks of asthma in the most marvellous way.

There is no treatment for influenzal pneumonia of the least avail.

Avoid circumcisions unless they are urgently required. Such a case recently occurred at 82 years of age. He is immensely grateful for the relief that he has derived from the operation. Is this unique?

Remove adenoids and tonsils whenever in doubt; most remarkable improvement results in the bulk of children.

Avoid morphia as you would the —— in an abdominal case until you *know* the cause of the trouble. It was given to a ruptured gastric ulcer in a patient of mine by another doctor, which hid the symptoms and made me undertake the operation too late to save life.

Wash stomachs out (a beastly operation) when the least dilated. I have had half a dozen remarkably successful cases.

I am in charge of a crêche. Give babies (9 out of every 10) pure milk (unboiled) and brown sugar every three or four hours; you must not dilute. The pollutions, unless very severe, are an outworn bugbear. You will grow magnificent babies.

In rheumatoid arthritis, especially when not desperately severe, use Parke-Davis' Phylacogen for rheumatism; you will obtain most gratifying results.

Sour milk is very useful in chronic colitis, although now forgotten.

Antimonial wine is a golden panacea for the bronchitis of the aged, either acute or chronic.

Five or seven drops of laudanum three times in the day will wipe out chilblains like a charm.

Cod-liver oil is nauseating and useless in my experience.

Tonics are mental, but immoral.

Observation and palpation are more reliable than X-rays and bacteriology.

VAUGHAN PENDRED, F.R.C.S.
H.-S., 1895.

Officers Training Corps.

Dear Mr. Editor.—The War Office has decided that the Officers Training Corps should continue, and those in whose hands rests the University of London Contingent of this Corps have asked me to carry on the work at Guy's. Before the war I felt very like the man who crammed a pupil in the Chinese language; he learnt up before breakfast what he could teach before lunch, and allowed no questions to be asked. Now that I do know something about what I should have to talk, I felt I could hardly refuse. I write therefore to you, Sir, to put before the students in the same copy of the Gazette as you publish the official notice, certain reasons that they may have for joining this Corps. And first I will enumerate certain reasons for which I do *not* want men to join. I do not want the man who will join if we have a Guy's badge on the uniform; to him I would say, "Go a few steps down the Boro High Street and buy a tie." I do not want the man who will join if we have a section of Guy's men only. To him I reply that my pleasantest remembrance of the O.T.C. was the fact that one met students from other hospitals, and from other

Universities, that if enough Guy's men join to complete a section we shall have it, but if they do not we shall chip in with another hospital. I do not want the man who will join because in that way he can get a cheap enjoyable holiday. It is true that he will enjoy the time in camp if he put his back into the job in the same way as a man enjoys any work which he takes up with enthusiasm. But if he joins *in order to* get a pleasant holiday he will probably get a most unpleasant and boring one. Above all, I do not want the man who takes it up for a short time, only to drop when some new thing comes along, and then tries to cry off his side of the bargain. The Corps is run on grants paid by the Treasury through the War Office for work done by the cadets. To join the O.T.C. infers a contract between the cadet and the Corps that he will do this work in order to earn the grant spent on him or he will himself pay that sum which has been spent. Supposing that a cadet wishes to back out before he has earned that grant—as many did in the old days—I shall insist that he pays that sum —as many did *not* wish to do in the old days— and unless his reasons for his failure to keep his word are very cogent, I shall not hesitate to advise the University to put their solicitor on his tracks and if necessary to take him into the County Court. Conversely, if he drop out through no fault of his own I will guarantee that he shall not lose by it. If then I do not want these men, what men do I want? I want men to join who think they will do some good by the added knowledge they will gain thereby, who hope they may get some good from the advantages offered them, who realise that it will mean some effort to carry it through, and who are prepared to stick it through that stage of ennui which comes over one at some period in every new thing one takes up, so that they attain that further stage in which they reap the advantage of their effort.

One used to urge it as a duty that all should join some branch of the Territorial Force in order that one might be of more use when there came that war which some thought inevitable. We cannot urge that now; we hope that no other war will be inevitable but that if it occur it will be only as the result of the clumsy methods of those who should prevent it. We used to be called "militarists" for our pains. I never have quite understood the term, and I doubt now whether those who used it ever knew what they meant by it. I do not doubt that we shall be called it again or that those who use the term will still be ignorant of what they mean. In part they mean that they think you are an eager person for war likely to urge the nation to it from sheer exuberance of spirit and demand for an open life. That those who join the T.F. or O.T.C. have such views I deny absolutely. Those who do such things are for the most part more peacefully inclined than those who do not; it means so much more to them. I believe it was so in the days that are past; I am sure it is so in the days that are present. Because one says "If there be another war, I shall be there" he does not say "Let's get on with having another war." In fact, because he says the first he is less likely to say the second. We hope there will be no more war; we look forward to the ideal when there can be no more war; but with the present state of society we can hardly bet on either for a few years. Not "when" but "if" another war comes in our time, let us be more prepared for it than we were. By this I am not joining with those who shriek how the Government was unprepared in 1914; I am referring to a personal preparedness. And for what would I have all men prepared? Would I have them prepared so as to increase the power of the Army as a slaughter machine? No! I would have them efficient in order that they might mitigate the beastliness, the muddiness, the bloodiness of war. Much of our horrors and our discomforts in the late war were due to our inefficiency. When it started we knew nothing. Those who had been in the T.F. before the war knew they knew nothing. Many who joined after did not know even this, and thought they could step from civil to military life and be as efficient in the latter as in the former. Some even now have not learnt it. And yet how many lives were lost because we did not know how to look after our men; how to feed them, to house them, to clothe them, or to keep them clean. How much unnecessary sickness was there from this reason; how much misery and discontent because we did not know how to keep their minds occupied or to give their souls the food they craved for. Much of this could have been avoided had we had a bit more knowledge first. We have acquired that knowledge after four and a-half years of strenuous work. Let us pass it on to others so that they may be the cause of less unhappiness in the future than we were in the past.

The old tags need re-casting. *Dulce et decorum* —True—By the death of millions of men the war has proved this. But it has proved more. It has proved that it is not very hard when it comes to the point. It has proved further that it is damned hard to live for that country for which it is not so hard to die. And because so many have died it is up to us all the more to live for it. I believe a soldier's life teaches this better than anything. I think perhaps we have learnt a little of it in these last years. I know of no class in which so high a sense of duty is developed as in the Regular Officer. At times his idea of duty differed from ours, but its sense was there. If then we can graft the soldier's sense of duty on to the

elasticity of the modern young civilian, how much better for us? Perhaps better for others as well. I am not only writing to those students who had the misfortune to be too young to go to the war. I am also writing to those who have had the very good fortune to come back from it. There must be much that they have learnt that is now floating in a jumbled manner through their brains that wants sifting and arranging. Of it one can make much use in life if it is so arranged, and it can best so be by taking thought and by reasoned discussion with others who have had similar experiences. I would suggest that such can best be got by giving up a few hours a year to these military subjects. It is not right that a man should give up all thought of what he has been through. It is the same with our war thoughts as with war books. I would not have people think only of the war any more than I would have them read only about the war. But when one says "I never read war books; I am sick of them"; I reply "But it is only now that books on the real war are being written." So also it is only now that our thoughts are really being sifted out to tell us what we have learnt and what we have yet to learn, and how we can apply that which we have learnt to the civil life of to-day and to-morrow. That is the great use that can be made of the war, and above all can it be made in medicine. We have learnt to deal with men in the bulk rather than with patients as individuals, or bits of patients as diseases or anatomical regions. On all sides this knowledge is being used in the school, in the factory, in the office, and the farm. But it is not being used enough. It has hardly crept into the hospital and the medical curriculum at all. We are still dealing with the person after he is ill, as we always must, but we must more and more deal with him before he is ill. The public side of preventive medicine has worked wonders in our cities and the countryside. Outside the Army the personal side has hardly been touched. As great advances in this part of sanitary science may be expected in the next fifty years as have been attained in the last fifty years from drains and water purification. Many have learnt a few tags of this in the Army. In the O.T.C. they will have the opportunity of learning more, and of applying what they know to what they have to do. At present there is but little chance of learning it in the official curriculum. True, a student will not be examined in it, but I can assure him that once he is past the period of examinations he will be able to make more use of it than of much of what he learns for his examination.

Then there is that other old tag that if you want peace you must prepare for war. There must be very few people who would still interpret this literally. Perhaps there are a few who still think that the way to stop war is so to pile up navies and armies that no one will dare to attack us, so to be in a "state of readiness" that everyone thinks we are going to attack them. Just as the Paleolithic culture extended down to the time of our grand-parents in Tasmania, so these views are not dead yet; but they are about as important to the life of to-day as was that culture to the life of our grand-parents. I do not ask men to join the O.T.C. for this reason, but I do ask them to join it so that they may not forget what war is like, and may cast their eyes forward and envisage what it will be like in the future. Then I think all will the more exert their influence to stop it again coming about. I have found that the nearer one got to the business of the war the less were its passions felt. The intense hate, the reviling of the enemy, the refusal to see any good point in his behaviour varied directly with the square of the distance away from him. At the bottom it is men's passions which make a war. If you want peace prepare *yourself* for war. It will enable you to remember what the war was like; it will keep down those passions which urge you to war; and it will make you put the whole weight of your influence on the side of peace.

I would not have anyone join until he knows what he is in for. During the winter I propose to limit the training to a series of talks on military medicine dealing with the care of the soldier. I would suggest that men come and see what it is about, and decide after a month whether they intend to join. Then those attendances that they had already put in would count towards their training. —I am, dear Mr. Editor, Yours very sincerely,

T. B. LAYTON.

Guy's Hospital, S.E.1.
12th October, 1920.

NOTICE.

University of London Officers Training Corps.

MEDICAL UNIT.

1. Students taking the Medical Course are invited to join the above Corps.

The Rules, which are signed by the Cadet on enlistment, are attached to this notice (vide Appendix I.).

2. The Corps is carried on by grants paid by the War Office. These grants are paid for each Cadet who makes himself efficient, and for the certificates which the Cadets gain. Hence the money is spent on the Cadet before he earns it. By Rules 9 and 10 the Cadet agrees to become efficient two years

running, and to take Certificate A, and in default to pay that money which has been spent on him but which he has failed to earn for the Corps.

3. To become efficient he must attend 20 instructional parades during the year, and must attend camp; but Officers Commanding Sections are allowed to use their discretion as regards camp when they know their ward duties prevent a man attending provided he has done his best to become efficient in other ways.

(N.B.—The word parade includes a lecture, class, demonstration or other form of instruction, vide paras. 8 and last).

4. The Medical School at Guy's Hospital has laid down that any man in the wards attending camp for two weeks shall only count this as one week towards the four weeks' holiday in the year to which a student in the wards is entitled.

5. The School has further requested members of the Staff that they shall give first preference of holiday to members of the O.T.C. attending camp during the weeks that this takes place.

6. For Certificate A the Cadet is expected to know the rudiments of drill, first-aid to the wounded, the means of collection and transport of the wounded, and to have some knowledge of Army and Army medical organisation, of medical tactics and of the medical subjects mentioned in Appendix II. to this Notice.

7. The syllabus for Certificate B is set out in detail in Appendix II.

8. It is probable for some years that all Cadets joining will already know the purely military subjects needed for Certificate A, as they will either have served in the Forces or have been in the O.T.C. at school. I propose, therefore, to make the instruction take the form of classes dealing with medical subjects in the light of the late war during the winter terms. Medical tactics, etc., may occupy the summer term. The pure military subjects I intend to keep for camp, and to limit them even there to the minimum. (A syllabus of the classes to be given are attached to this Notice as Appendix III.).

9. Officers who have held commissions in the Territorial Force, Special Reserve, or who have held temporary commissions during the war are eligible for enrolment as Cadets in the Medical Unit provided that the students concerned have not served overseas as Medical Officers. Officers so enrolled retain their rank except when on parade with the Officers Training Corps (Authority War Office letter 9/O.T.C./1298).

I hope that many such officers will join. Their knowledge of military subjects will enable them to take greater advantage of the instruction than is possible for others to do.

10. In future candidates for commissions in the R.A.M.C. who hold either Certificate A or Certificate B will be entitled to the following advantages:

Certificate A (Medical): To receive 3 per cent. of the maximum number of marks allotted to the compulsory subjects in the entrance examination.

Certificate B (Medical): To receive 6 per cent. of the maximum number of marks allotted to the compulsory subjects in the entrance examination.

(Authority War Office letter 9/O.T.C./1763).

11. The Lords Commissioners of the Admiralty have agreed that candidates for the Royal Naval Medical Service who are in possession of Certificates A and B (Medical) shall be entitled to advantages similar to those accorded to candidates for commissions in the Royal Army Medical Corps.

(Authority War Office letter 9/O.T.C./1763).

12. By Army Order 302 of 1920 officers on first appointment to the Special Reserve or the Territorial Force will be granted seniority as follows:—

(1) If they have by examination obtained Certificate B (Medical) in the Officers Training Corps, six months' seniority.

(2) If they have obtained Certificate A (Medical), three months' seniority.

And on mobilisation such officers who have obtained Certificate B or Certificate A (Medical) shall be considered for appointments in preference to those not so qualified.

13. Army Order 302 of 1920 lays down that, as far as possible, medical practitioners who are required for service in an emergency will be commissioned into the Special Reserve or Territorial Force, under the same conditions of service and same rates of emolument as apply to officers of those Forces, and that in the event of it being found necessary to grant temporary commissions, officers to whom such commissions are granted shall not receive more advantageous emoluments than those applicable to officers of the Special Reserve and Territorial Force.

14. It will be seen from paras. 10, 11 and 12 that considerable advantages are to be gained by anyone who has been in the O.T.C. and who enters one of the Services, whereas the Army Order quoted in 13 protects those members of the O.T.C. who take a commission from being treated in the way as were men who had done a similar thing before the war, and who found others who had done nothing in peace time joining up at great financial advantages over themselves.

15. I am arranging that the Medical Unit of the O.T.C. shall be used for the study by research of one or more of the numerous physiological problems in connection with the soldier which the late war

has brought forward. I have no doubt that I shall be able to complete these arrangements by the summer.

T. B. LAYTON,
Major, R.A.M.C.(T),
O.C. "B" Sect., Medical Unit, U.L.O.T.C.

APPENDIX I.

Rules.

1. Admission to the University of London Contingent is restricted (see also Rule 2 below) to gentlemen who are Members of the University of London, or are non-matriculated students pursuing a regular course in Schools of the University, save that, subject to such Regulations, if any, as may be prescribed by the Military Education Committee of the University, power is reserved to the Commanding Officer in special cases to admit gentlemen who, though not comprised in either of the foregoing categories, are desirous of gaining the certificates of proficiency obtainable in the Officers Training Corps.

2. The Corps is intended for the preliminary training of young men with a view to their qualifying for commissions in the Special Reserve of Officers, or the Territorial Force, and membership of the Corps is restricted by the Army Council to British subjects of pure European descent.

3. Cadets must obey all Rules and Regulations for the Corps, whether made or to be made, by the Army Council, the University authorities, the Commanding Officer, or other lawfully constituted authority.

4. Cadets must obey all lawful commands, and orders given by, and do all such things required by, the Commanding Officer or other superior officers.

5. Cadets enrol for two years. At the conclusion of their term of enrolment, Cadets may re-engage annually, for the purpose of obtaining Certificates A or B; but they will not, unless in very exceptional circumstances, be permitted to serve more than four years in all in the Contingent.

6. Before enrolment in the Contingent, and on re-engagement, a Cadet must be accepted by the Commanding Officer.

7. Resignations from the Contingent must be sent in to take effect at the end of the Academic year (October 1st).

8. Cadets incur no pecuniary liability, except in the cases provided for under Rules 9, 10, 11, 12, and 14 below.

9. Cadets leaving the Corps at the end of two years without having obtained Certificate A must pay £1 as Clothing Money towards cost of uniform.

10. A Cadet who desires to retire at the end of the first year may do so on payment to the Corps Funds of the Capitation Grant for one year (£4), in addition to the sum of £1 as Clothing Money towards cost of uniform. A Cadet in possession of Certificate A is exempt from payment of Clothing Money.

11. Every Cadet, unless prevented by illness (duly certified), or such other cause as the Commanding Officer may deem sufficient, is required to make himself efficient each year according to the conditions laid down for the time being in the Regulations for the Officers Training Corps. Any Cadet not so efficient is required to refund to the Corps the amount of the Capitation Grant.

12. The Commanding Officer shall, in cases of misconduct, have power summarily to dismiss any Cadet; in such cases he shall immediately acquaint the University and College Authorities with the reason for his action. Any Cadet so dismissed shall be liable for the amount of the Capitation Grants for the full period of enrolment.

13. Every Cadet shall notify the Commanding Officer within three days of any change of address.

14. Every Cadet, on leaving the Contingent, must hand over arms, uniform, and equipment in good order (fair wear and tear excepted); otherwise he must refund the full value of any missing or damaged article.

APPLICANTS FOR MEMBERSHIP OF THE MEDICAL UNIT MUST BE MEDICAL STUDENTS PURSUING A COURSE OF STUDY FOR REGISTRATION AS FULLY QUALIFIED MEDICAL PRACTITIONERS.

16. Applicants for membership of the Contingent must undergo a medical examination under arrangements made by the O.C. the Company or Section they desire to join, and produce a certificate to the effect that they are physically fit to undertake the duties of a Cadet in the Contingent. Cadets desiring to resign their membership of the Contingent for medical reasons before the end of their term of service will undergo a medical examination under arrangements made by the O.C. their Company or Section, and the certificate of the Medical Officer examining will be forwarded to Headquarters with other papers relating to the resignation.

Note.—Attention is drawn to the fact that the training year for the Officers Training Corps extends from October 1st in any year to September 30th of the following year. The requirements for efficiency in any year must be completed between these dates.

APPENDIX II.

For Certificate A.

Elements of Practical Sanitation.—This, as bearing upon prevention of disease, must be prefaced by a lecture on principles.

When ground is available for digging and construction, the Cadet must practice the work, under instruction, in term time.

Prevention of Disease.—Will be taught by lecture, and the Cadet at this stage will be expected to have a general knowledge of the preventable diseases (from the lay point of view) which occur in active service, and the means of preventing their incidence and spread.

(He is not yet expected to know anything about their symptoms or treatment).

Restoration of Morale of Battle-tired Troops.—Measures taken during the war for the relief of mental monotony and the physical refitting of men from the front line.

Prevention of Venereal Disease.

Properties and Ranges of Various Weapons and the Kind of Injuries they Inflict, including Gas Warfare.—The properties and range of weapons is a military subject, and must be taught by an initial lecture.

"The kind of injuries they inflict" means the general nature of the injuries caused by high explosive shell, shrapnel, rifle fire, bombs, &c., dependent on the size, shape, and velocity of the projectile.

For Certificate B.

After having taken Certificate A, his further training for Certificate B is directed to the more specialised medico-military education, as he will by this time have entered upon the subjects of medicine, surgery and hygiene in his medical curriculum.

The standard to be aimed at is that which would be required of a lieutenant joining a Special Reserve or Reserve unit of his own branch of the Service on the outbreak of war, and liable to pass from it to a regular unit in the field.

The several capacities in which a Junior Medical Officer may be employed in the field are:—

(1) As a Medical Officer in charge of a combatant or administrative unit.

(2) In a field ambulance, which is a divisional unit.

(3) In a hospital train, hospital ship or ambulance convoy.

(4) In a casualty clearing station, which, though it is officially a L. of C. unit, embodies some of the conditions of work of a divisional unit.

(5) In a L. of C. unit, such as a stationary hospital.

(6) In a base medical unit, such as a general hospital.

In every one of these situations, the knowledge he will have acquired in the Officers Training Corps will be of use to him, but in (5) and (6), where the deliberate treatment of wounds and sickness under hospital conditions forms the chief part of his work, military knowledge, though important, is less essential than in the more advanced units under war conditions, and in (2), (3) and (4) military knowledge is essential to efficiency, and it is to this that the Officers Training Corps training is directed.

In this particular connection (Medical Officer attached to a unit in the field (1)), the knowledge of the characteristics and functions of the various arms, combatant and administrative, is of the highest importance. This information forms the subject of the first paper for Certificate A.

For the intelligent performance of his duties in any of these capacities he must have a greater knowledge of detail than was required for Certificate A.

He must know, under the heading of *Organisation* and *Administration*:—

The points of contact between his own medical unit and the branches with which he has to deal.

The structure and functions of the unit and its limitations.

Duties in connection with demand and interior economy.

The range and detail of his duties as a junior officer of the unit, under varying circumstances.

Under the heading "Such a knowledge of the tactics and procedure of all arms as is necessary to a medical officer attached to a unit in the field."

A more intimate knowledge of the above subjects than was required for Certificate A is now necessary.

His relationship to the unit to which he is attached and to the divisional medical administration.

The details of his duties to the unit under varying circumstances.

Points of contact between his regimental medical establishment and the divisional units, its interworking with the field ambulance in battle.

These matters require the acquisition of knowledge which is partly military and administrative and partly medical and sanitary.

The military parts of them are:—

Discipline and Military Law to govern his dealings with the personnel and patients under his command in a medical unit, and his own responsibility to his immediate commanders and higher authority.

As in Medical Charge of a Unit other than Medical, its tactics and procedure.

The laws and customs of war and the provisions of the Geneva Convention, under which he carries out his duties.

The Administrative Part.—Matters connected with the housing, clothing, feeding and payment of his men and patients, their transport and the disposal of casualties and their arms and equipment, documents used on field service in these connections, and his points of contact with the various departments concerned.

The Medical Part.—Treatment of wounds under active service conditions, and with a view to the preparation for transport of patients by various vehicles.

Diseases incident to active service, the principles of their treatment and the prevention of their spread. Malingering.

The Sanitary Part.—As the main function of the Army Medical Service is that of keeping the Army effective in numbers, the sanitary part of a Medical Officer's duties is, from the State point of view, by far the most important, as it is directed to measures which preserve the health of the soldier.

In this connection, everything that bears upon the health of the soldier must receive attention, under the following heads:—

The health of the soldier in barracks, bivouacs, camps, billets and trenches, comprising his housing, clothing, food, bathing and personal ablution, washing of clothes, amount of work, hygiene on the march.

These conditions are, in the main, governed by the exigencies of the campaign, and by legislation from headquarters, but they must be understood by the Medical Officer in charge of troops, who is responsible for watching them and making representations on the subject when necessary.

Water Supply and Purification of Water.—Use of chlorinating plant and other means of purification, and testing for poisons. Here again, arrangements for supply and distribution of water and its purification in bulk are outside the functions of the Regimental Medical Officer, but he has to watch the supply and purification of the water for his unit, and to take action when necessary.

Food of the Soldier.—Food values.

Inspection of foodstuffs.

The kind and quantity of the ration supplied in the field is a matter decided by higher authority; the Medical Officer has to judge of the quality as supplied to his unit and its cooking.

Clothing.—This is supplied centrally and varied according to climate, but the Medical Officer must see that it is properly used from the point of view of health and must be able to institute measures for its washing, and for the prevention of vermin and disinfection when necessary.

Prophylaxis of Diseases Common in War.—Especially enteric fever, dysentery, cholera, diarrhœa, malaria, cerebro-spinal meningitis, relapsing fever, trench fever, typhus.

He must have a knowledge of the causes and mode of spread of such diseases, and of the means necessary to prevent and combat them.

Flies, Lice, Scabies, and Biting Insects as Causative of Disease.—Their agency in causing disease, their identification and habits, means of protection against them, and for their destruction when feasible.

Disinfection and Sterilization in the Field.

Methods of Sanitary Conservancy in the Field.

Inspection of railway stations, dockyards, supply dumps, and other places where troops are constantly coming and going.

APPENDIX III.

Classes on Military Medicine.

Syllabus.

Part I.—The Care of the Soldier.

1. Moral.
2. Food.
3. Load weight.
4. Clothing.
5. Water.
6. Cooking.
7. Fuel.
8. Washing.
9. Lice.
10. Disinfestation.
11. Quarters: Billets, Camps and Bivouacs.
12. Flies, Fleas and Mosquitoes.
13. Mental occupation.
14. Venereal disease.
15. Marches.
16. On Board Ship.
17. Embarkation and Disembarkation.

Part II.—Curative medicine from the standpoint of the M.O. i/c Unit or in a Field Ambulance.

1. Sick parade.
2. The louse-borne diseases: Impetigo, septic sores, trench fever, typhus, relapsing fever.
3. The fly-borne diseases: typhoid, the dysenteries, cholera, diarrhœa.
4. The mosquito-borne diseases: malaria.
5. The flea-borne diseases: plague.
6. Other diseases.
7. *Oscillatio Plumbi* and *Hæmorrhagic Kyphosis*, (acute and chronic).

Detail of First Lectures.

Moral.—Napoleon's maxim; what it is; its application to the medical side of military science; to civil medicine as well; the Medical Officer's power to raise it; in a battalion of infantry; in a brigade of artillery; in other units; in a field ambulance. His dual duties; as an officer, as O.C. personnel under

him; as a doctor to prevent disease and to treat sick and wounded; most of his time doing first of these two last; prevention; its importance; its neglect in the past in civil life; its increasing importance in the future; application of what is learnt in Army to civil life; in factories; in schools. Sanitarians; all Medical Officers act as such at some time; characteristics of a good one.

Load Weight.—Weight carried; Infantry, R.E., R.A.M.C., R.F.A.; its relation to mobility; its relation to man-power; to moral of troops; falling out; a pressing subject; need for education of physiological principles among combatants; pre-war research; relative claims of iron ration and more ammunition; mules and men; articles since added; gas helmets; Mills bombs; Lewis guns; Very lights; picks and shovels; bivouac sheets; second water bottle; mobile ration; some weights carried.

Clothing.—Protection against wet, cold, sun; need for freedom of action; instant readiness; not merely a question of heat-stroke; men more often in a position where they suffer from cold or wet than from heat; the webbing equipment; tunic; collar; buttons; serge; drill; trousers; shorts, ease of latter, for hills, on the level; sweating crutches; flaps for night against mosquitoes and cold; back of trousers best place for first field dressing; shirts; vests; pairs of socks; one or two of each; material; the greatcoat; the sheepskin jerkin; mackintosh capes; relative advantages of each; blankets; experience of Katerini; boots; size; fitting; loose or tight; question of second pair; personal care of boots; importance in relation to health; polish or grease; toe and heel caps; nails; what can be done; by an individual; by organisation; by a cobbler; Turkish pack-saddles.

Water.—Physiological needs; variation in individuals; relation to constipation; to illness; to fatigue; ignorance of combatant officers on this subject; their ideas of the extent to which water discipline can go; need for Medical Officers to teach them; their willingness to learn; ignorance of Medical Officers; Melville's work; the half-gallon ration; no military operations should be undertaken on less; always more if possible; means of carriage; water-carts; fanatis; petrol tins; water-bottles; value of containers; a "backshi" water-cart; methods of issue; tea; in the stew; for cooking vegetables; into water-bottles; quickly but without waste; need of discipline; of ladles; funnels; of taps; disadvantages of taps; best time to drink; water discipline; its importance; its difficulty; water from unauthorised sources; the Wadi Sheria; risks run; water purification; always in bulk when possible; cleaning of containers; often forgotten; routine reports; likely to be missed; the Commanding Officer's water-bottle; the water-bottle in the medical equipment; cooks, batmen, Q.M. storesmen, transport men, the adjutant's clerk; methods of doing it; hot water and tea; permanganate; parades and delegation of authority.

Food.—Number of kilo-calories needed; caloric value *not* the whole question; proteid; carbohydrate; fats; vitamines; variety; appetite; variations in appetite; in different men; in same man at different times; enormous appetite of young soldiers; after hardships; during convalescence; craving for sweet-stuff; question of bulk; feeling of satisfaction; rations; soldier entitled to what he can eat; not to what he can waste; watch the rubbish tubs; full of food; or empty; complaints; mobile ration; iron ration; issue of rations; central feeding; men on detailed duties; medical comforts; in units; in field ambulance; to all patients; to individual patients; in hospital; extras; importance of attention of medical officers to diets.

Papers by Guy's Men.

Sir Wm. Hale-White, K.B.E., M.D., An address on Medical Problems: Then and Now. Being a Presidential Address at the Opening Meeting of the Medical Society of London on October 11th, 1920.—*Lancet,* October 16th, 1920, p.775.

Ralph Thomson, Ch.M., F.R.C.S., The Operative Treatment of Congenital Deformities of the Lower Urinary Tract, with special reference to the formation of a Compressor Urethræ (illus.).—*Ibid,* p.790.

Hildred Carlill, M.D., Hysterical Anæsthesia of the Eyeballs: Cutaneous Artefacts; Voluntary Regurgitation of Stomach Contents.—Proc. Roy. Soc. Med., XIII., Clinical Section, p.79.

Philip Turner, M.S., Fracture of the Left Humerus; non-union (Pseudo-Arthrosis) after 34 years.—*Ibid,* p.87.

A. W. Ormond, F.R.C.S., Case of Von Recklinghausen's Disease with Acromegaly.—*Ibid,* Sec. of Dermatology, p.124.

H. W. Barber, M.D., Case of Pityriasis Rubra Pilaris.—*Ibid,* p.126.

T. B. Layton, F.R.C.S., A Case of Frontal Sinusitis.—*Ibid,* Sec. of Laryngology, p.165.

Sir Charters J. Symonds, K.B.E., C.B., M.S., Total Laryngectomy (Extract).—*Ibid,* p.190.

Wm. M. Mollison, M.Ch., Tonsillectomy for Rheumatoid Arthritis.—Proc. Roy. Soc. Med., *Ibid,* p.242.

Wm. M. Mollison, M.Ch., Case of (?) Vertigo.—*Ibid,* Sec. of Otology, p.163.

David Forsyth, M.D., D.Sc., F.R.C.P., Psychoanalysis of a Case of Early Paranoia Dementia.—*Ibid,* Sec. of Psychiatry, p.65.

E. P. Poulton, M.D., Case of Diabetes Insipidus (Abstract).—*Ibid,* Sec. of Therapeutics and Pharmacology, p.97.

A. F. Hurst, M.D., F.R.C.P., The Functional Element in Disease.—*British Medical Journal,* October 23rd, 1920, p.623.

Guy's Hospital Physiological Society.

The Annual General Meeting of the Society was held on Tuesday, October 12th, 1920, to read the Report and Balance Sheet of the past year and to elect the officers for the ensuing session. Professor Pembrey was in the chair.

The Balance Sheet was most satisfactory, showing a credit of £3 0s. 5¾d.

The following were the officers elected:—

President.—Professor Pembrey.

Vice-Presidents.—Professor Johnston, Dr. Ryle, Dr. Hurst, Dr. Laidlaw, Dr. Marshall, Mr. Ryffel, and Mr. Evans.

Secretary and Treasurer.—Mr. Wooldridge.

Committee.—Messrs. Spurrell, Housden, Parsons, Shaw and N. W. MacKeith.

The subscription remains at 3s. 6d.

A Ballot was taken on the three best papers read during the past session to compete for the President's prize, and those selected were Mr. Spurrell's paper on Glycosuria, Mr. Apsey's paper on Hypnotism, and Mr. Toussaint's paper on The Higher Education of Women.

The decision will be announced later.

A vote of thanks to Mr. Spurrell was proposed by Mr. MacKeith, and heartily accorded by the House. Mr. MacKeith spoke of Mr. Spurrell's untiring efforts in putting the Society on a workable basis after the war, and the excellent results obtained during last winter.

Mr. Spurrell replied that it had given him great pleasure to do the work, and if good had resulted from his efforts he was amply repaid.

The meeting closed with a vote of thanks to Professor Pembrey for taking the chair. Thirty-eight members were present.

A meeting was held on Thursday, October 21st; Dr. Laidlaw in the chair.

Mr. Sears read a paper on "Sleep." On the meeting being thrown open a lively discussion followed. The Dendritic theory occupied a prominent position, and at times was a source of much amusement.

Fifty-seven members were present.

The meeting closed with a vote of thanks to the speaker, and to Dr. Laidlaw for taking the chair.

The Secretary apologises for any shortage in the catering, but did not anticipate such a good attendance.

TRISTRAM WOOLDRIDGE,
Hon. Secretary.

Guy's Hospital Musical Society.

This Society, with which is incorporated the Nurses' Choral Society, holds choral practices every week on Fridays at 8 p.m. in the Court Room. It is particularly hoped that during the present academic year more men, especially those with previous school experience of choral work, will find time to come to the practices and help to make the Annual Concert to be held on Shrove Tuesday the success that it used to be in the years before the war.

Now that all the old Hospital activities have been established on a pre-war basis it is proposed to re-start the old Glee Club. This Club is for the practice and performance of part songs for male voices, and practices will be held in the Residents' Room in the College (by kind permission of the President of the Residents) every Friday at 5 p.m. These practices, like the Choral practices, will be under the direction of Mr. H. St. J. Bradford, the Hospital organist.

The Society hopes further to be able to form an orchestra if sufficient instrumentalists are available. It is proposed at first to hold a few practices with all available instruments. If these are successful and well attended it should be possible for the orchestra to contribute items to the Society's Annual Concert.

Notices will from time to time be placed in the Students' Club, and all interested in music are asked to look out for them.

Finally, the Committee wishes to emphasise the two great difficulties with which the Society has to contend. In the first place the weekly practices are the absolute minimum required if really good work is to be done. Regularity of attendance in so far as it is compatible with Hospital work is, therefore, very important. Secondly, there is a great dearth of men's voices, especially tenors. It is a not uncommon experience for the practices to be attended by only one or two men as compared with 30 or 40 nurses. If the concert is to be given this disproportion must be remedied. All that intending members are required to do is to turn up *in the Court Room on Fridays at 8 p.m.*

MAURICE E. SHAW,
CHAS. E. GALLAGHER,
Hon. Secs.

Notices.

Neurological Out-Patients.

Dr. Symonds will examine and teach upon selected cases on the Ear, Nose and Throat floor on Wednesdays and Saturdays from 9.30 a.m. till 12.30 p.m.

In addition there will be 12 o'clock demonstrations on the Eye floor from time to time by Dr. Hurst and Dr. Craig, notices of which will be posted in the Colonnade.

Guy's Hospital Clubs' Union.

At a meeting of the Clubs' Union Council held on the 21st inst., the following motions were carried:

1. All railway fares over and above 2s. 6d. be paid by the Clubs' Union in respect of all teams, senior and junior, playing away matches. These fares must be included in the annual budget of each club and submitted to the Clubs' Union Council for approval.

2. All lady visitors to the ground at Honor Oak Park be charged the same price of admission as men, with the exception of the Guy's Hospital Nursing Staff.

W. D. DOHERTY, Hon. Sec.,
Clubs' Union Council.

Pavy Gymnasium.

Boxing.—Classes are held every Monday night from 5 p.m. to 7 p.m. The instructor is Mr. Alf. Hewitt. These classes commenced early in September since we had a fixture with Oxford University on October 23rd. An account of this will appear in the next number of the Gazette.

Gymnastics.—Classes are held every Friday evening from 4.30 p.m. to 6.30 p.m. It is hoped that a team will shortly be raised to compete with the City of London School. In addition to this, efforts are being made to get together a sufficient number of men to give a display before Christmas.

Fencing.—Classes are being held at present four times a week under the direction of Mr. W. H. Foy. The times of the classes are Tuesdays and Wednesdays, 5 p.m. to 6.30 p.m.; Thursdays and Fridays, 12.45 p.m. to 1.45 p.m.

For the benefit of new men it may be stated that the Pavy Gymnasium is situated in the College underneath the glass roof in the quadrangle. There is no membership fee; all members of the Clubs' Union are members of the Pavy Gymnasium. It is hoped that all men who are interested in any or all of the above sports will come along to the classes.

There will be an Inter-Hospital Competition some time towards the end of next term, and there is an Inter-Hospital Cup to be won back. The Cup is at present held by the London Hospital.

So come along Guy's!

Football.

GUY'S v. NEATH.

Great was the victory at Honor Oak Park on Monday, October 11th, when the Hospital beat Neath by 1 penalty goal, 1 dropped goal, and 1 try to nil.

There was again an excellent ring of spectators at the Hospital ground when these teams faced each other. Mr. Trollope, the Hon. Secretary of the London Society of Rugby Union Referees, was in charge of the game, and very firmly he controlled it. Our men soon found out they were up against a very smart and hard trained team, and play settled down to hard Rugby football, so hard as to be almost relentless, and both sides gave their best as far as tackling and grim scrummaging went. No one spared themselves, and men went down to the foot rushes with a pluck and determination on both sides good to witness.

Quite early in the play we had a penalty awarded us, and this Van Schalkwijk opened the scoring with, the outside half dropping a neat goal. Greatly encouraged—you will remember Neath came to us elated by their big win over Northampton on the previous Saturday—Guy's resumed with great dash, though for a few minutes the visitors' forwards pushed us dangerously near our line. A penalty gave us relief. From a scrum Bekker whipped out to Van Schalkwijk, and so on to Krige, and then Albertyn secured, going well he pushed Thomas aside and scored amidst tremendous cheering. Reitz kicked well, if not successfully, for goal. Then before the interval we saw as rare a tussle forward as one could wish. Did the three-quarters get moving a hefty tackle brought the movement to a stop. It was refreshing to see Graham-Davies going straight for his man. Krige the same; while the way Albertyn and Reitz collared their men was very fine. Reitz figures well at three-quarter, and not a spectator but what felt absolutely confident of our back division after the first five minutes of the game. Olivier calm and certain; the grand line in front of him. Bekker as clever and untiring as his immediate opponent, Shon Thomas, and Van Schalkwijk, who right in his happiest vein not only dropped the penalty goal and opened the way for the try, but ere the interval was reached dropped an excellently judged goal; so we crossed 10 points to the good.

From now to the end there is little to detail. The gruelling contest was even. Twice our "threes" got nicely away, but we could not cut through and so clear the way for the wings. Pluckily Reitz played in his novel position, but no three-quarter movement lasted long. The forwards hung on, and their work in the follow up has seldom been better. Neser, Marais, Doherty and Shelswell covered enor-

mous ground. Macintosh was well to the front. Biddle as hard working as ever. Duncan and Van Zyl both dribbled and lent their aid most conspicuously. Seldom has a team so early in the season shown such team work, the XV. working as a whole under Doherty's splendid captaincy. I am sure the win was a surprise to those whose duty it is to write an account of these games, but no wielder of the pen denied but what the victory was well won—Guy's 1 dropped goal, 1 penalty goal, 1 try (10 points) to nil.

Guy's team:—W. Olivier, F. W. Reitz, H. Graham-Davies, J. A. Krige, P. K. Albertyn, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, A. H. Shelswell, C. Marais, A. H. Van Zyl, E. E. Neser, R. F. H. Duncan, F. J. Biddle, and C. Macintosh.

GUY'S v. HARLEQUINS.

A very foggy morning made us all tremble on the morning of October 23rd, lest this popular fixture would have to be abandoned. The mid-day hour, however, brought the sun, and a delightful afternoon resulted. The attendance was not quite up to the expected, probably many preferred not to journey to Honor Oak Park as in several districts the fog was still thick.

No doubt the Harlequins were weakly represented. V. G. Davies, the stand-off half, was hurt the week before; W. W. Wakefield, the International, and P. R. Simpson, another forward, could not get leave from the R.A.F., and Jacot was in the Oxford team at Richmond. The papers of Monday, the 25th, rather elaborated this weakness, but our job was to play the team that eventually turned up.

At 3.15 p.m. both sides took the field, and within a minute or so all the backs had handled the ball, and Albertyn, the last to receive, galloped in at the corner. A long shot at goal was fruitless. Then came a good try by Graham-Davies. There was much kicking after this, and both full-backs rather misjudged the flight of the ball. Probably the sun and haze made correct judgment impossible. After some little fumbling, our three-quarters put in some good passing, and again Graham-Davies sailed in after presenting the Harlequin full-back with a perfect "dummy" (to Steyn, who was in attendance). Van Schalkwijk goaled this try easily, and then dropped a beautiful left foot goal. Receiving from Bekker well outside the opposing "25," he ran to the left a short distance, and let fly from long range to gain a splendid four points. F. Bekker was hurt just before the interval, but very pluckily resumed, and for the rest of the afternoon played at his best.

Resuming after the interval, the game went on at a great pace. The forwards were in tip-top form, W. D. Doherty, C. Macintosh and E. E. Neser doing great things. A lofty kick and smart follow up, and King was bundled over with Reitz Marais and Neser all trying to get him off the ball. Strange to relate, we were penalised just after, when one thought the boot was on the other leg. Again King was at fault with a clearance, and Marais, who never fails to keep close up, gained a try, which Neser with a very fine kick converted. After this the Harlequins' best friends could not say much for them. Their opposition gradually weakened, and Steyn ran in twice; Bekker and Van Schalkwijk once each. Twice Van Schalkwijk converted, and thus concluded an excellent afternoon's work. Albertyn did all he found to do in determined fashion; in fact, all the backs were good, though at times a little uncertain in their handling. Just after half-time two or three forwards were sending the ball out anywhere and anyhow, trusting to some outside player to come across it. This will not do against a strong side; it is far too dangerous to trust your luck in that way unless you are either very much up on points or very much down and want points badly. The final score was Guy's 5 goals (1 dropped) 4 tries (36 points) to nil.

Guy's team:—W. Olivier, C. L. Steyn, H. Graham-Davies, J. A. Krige, P. K. Albertyn, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. H. Shelswell, C. Marais, A. H. Van Zyl, E. E. Neser, F. J. Biddle, and C. Macintosh.

The "A" XV. were without a match on Saturday, October 16th, owing to the inability of the Old Alleynians "A" XV. to put a representative team in the field.

GUY'S v. GLOUCESTER.

It is a long way to Gloucester by rail, and then to play a strenuous match with such a tough lot of players as the team that represent that distinguished city. However, there was nothing else for it but to go down on the same day of the match. Unfortunately we did not quite succeed in winning, though we hope that the return match at Honor Oak Park in February will see the tables turned. It is, without wishing to make excuses, a little difficult to accommodate one's play to the style of the Western Counties. The referee's rulings are different, the game played in rather a different manner, and the atmosphere not quite the same. Once or twice it seemed certain that we had scored, but no try was allowed, and with at least another penalty Van Schalkwijk had very hard luck, as his attempt hit the post.

It was unfortunate Doherty could not play, though Duncan made an excellent substitute; still Doherty's leadership is worth much. The Gloucester forwards were a very experienced lot of players, and, in addition to their knowledge of the game, were as hard as nails. S. Smart, T. Voyce, G. Holford and A. Hall are names known to all Rugby followers, and they played against us right up to their reputation.

Within a quarter of an hour of the start we were six points down, Thomas scoring one try and Webb the second. Steyn came to grief with a pass from Graham-Davies which looked as if it had only to be accepted to score,but not many chances came to our third line, owing to the rapid breaking up and hard tackling of the Gloucester team. But in this respect our own men were not wanting. Albertyn got going well till Smith, the Gloucester back, stopped him. But the game was almost all with the forwards. Neser, Biddle and Reitz were prominent, and though much good work was done we never looked to have a real grip of the game, the decisions going against us, and settled play seemed difficult. As the end approached Van Schalkwijk

dropped a goal from a penalty—thus the result was Gloucester 2 tries (6 points), Guy's 1 penalty goal (3 points).

Guy's team:—W. Olivier, C. L. Steyn, H. Graham-Davies, J. A. Krige, P. K. Albertyn, F. Bekker, J. G. Van Schalkwijk, F. W. Reitz, E. E. Neser, C. Marais, A. H. Van Zyl, A. H. Shelswell, F. J. Biddle, R. F. H. Duncan, and C. Macintosh.

NOMAD XV. v. ROYAL MASONIC COLLEGE "A" XV.

Played on the College ground at Bushey on October 16th. The School XV., being composed of boys of 15 years of age, was naturally at a disadvantage, though they played a very strong game.

From the commencement the Nomads proved themselves superior in speed and weight. Broido scored the first try out of a scrimmage in the home "25." Marsh, Thomas, Orsmond, Longhurst and Jarman added to this during the game. Ives, Hollingsworth and Orsmond played a noteworthy game in the scrum. The back line, helped ably by Longhurst and Worthington, invaded the enemy's country many times. Owing to the greasy ball, goal kicking, unfortunately, was a failure. Half-time score, 5 tries 1 goal (17 points); time score, 11 tries 2 goals (43 points).

Team:—Morris, Marsh, Jarman (captain), Broido, J. D. S. Thomas, Longhurst, Worthington, Hollingsworth, Ives, Orsmond, Strong, Dingle, Hofmeyer, Edwards, and Hankey.

GUY'S HOSPITAL v. HARLESDEN TOWN.

Played at Honor Oak Park on October 16th; drawn 1—1.

This game showed a marked improvement on the one of the preceding Saturday against H.A.C. Football Club. The forwards controlled the ball really well at times, and combination took the place of fruitless individual efforts. The half-backs marked their opposing forwards well, and it was not often that the Harlesden men broke through with a clear field ahead. In the first half neither team showed much superiority, and the play lay mostly in the middle of the field, attacks from either side failing to penetrate the defences. After a corner given against the Hospital, and a scrimmage in front of the goal, Harlesden scored a goal, which MacKeith had no possibility of saving.

In the second half the Hospital began to press, and the play was carried into their opponents' half. Couch, Lipschitz, Trott and Van Geuns were conspicuous for their hard work, and from a corner kick the first-named scored a clever goal for the Hospital, taking the ball from an almost impossible angle. Shortly after a penalty was given against the Hospital, but it failed to materialise, for MacKeith saved well. Harlesden got another clear opening, but placed the ball well over the cross-bar. The Hospital continued to press, but could not pierce the defence of the Harlesden backs, who were playing a vigorous game, and there was no further score.

Guy's team:—M. H. MacKeith, C. A. Wakeford, A. W. Riddolls, F. L. Rayner, D. H. Couch, A. H. Lipschitz, R. Van Geuns, R. G. Pengelly, J. C. Rowbotham, L. A. S. Trott, and J. C. Hewetson.

GUY'S HOSPITAL "A" v. EMMANUEL ATHLETIC "A."

Played at Dulwich on October 16th. At the commencement play settled down in mid-field. Soon our forwards showed their superiority in ball control, and gave the opposing defence many anxious moments. At the end of about fifteen minutes' play Nicholas, Crisp and Jones scored in quick succession. Emmanuel then scored following a break away. Before the interval we twice increased our lead.

On the resumption our forwards at once carried play to the vicinity of the home goal, where it remained for the most part till the final whistle. Close on time Wayman scored a fine goal from an almost impossible position. A pleasing feature of this match was the play of the forwards, who combined well and shot on the slightest provocation. Final score: 11—2.

Guy's "A" team:—E. Hardy, S. E. Sennitt, D. E. C. Robertson, T. Wooldridge, A. A. Danino, P. G. Trafford, T. E. Jones, B. Crisp, W. Nicholls, F. Nicholas, and H. Wayman.

GUY'S HOSPITAL "A" v. NESTANGLO SPORTS CLUB.

Played at Elmer's End on October 23rd. For this game, owing to injuries and the claims of the first eleven, four new forwards were brought into the team.

Nestanglo at once invaded our half, and Hardy was called upon to save many hard shots in quick succession. In this half our defence were very slow in tackling the man in possession of the ball. At the end of twenty minutes' play hesitancy on the part of two of the defence allowed the opposing centre-forward to break through and score. Nestanglo continued to press, and our forwards were only dangerous on three or four occasions in this half. Just before half-time Nestanglo scored again.

On the resumption our forwards played much better, and after five minutes' play Morgan reduced the lead with a long high shot. During this half our half-backs tackled much better, and placed the ball to the wing-forwards with good judgment. Three minutes later Nicholas scored from a pass from Morgan. Many good centres were now sent in from both wings, but the inside forwards lacked the necessary dash to turn them to good account. Just before time Nestanglo scored, leaving the final score 2—3.

Guy's "A" team:—E. Hardy, I. E. Harries, D. E. C. Robertson, P. G. Trafford, A. A. Danino, E. B. Corry, F. J. Smith, F. Nicholas, L. Froehlich, J. C. Hewetson, and V. R. Morgan.

Birth.

CUTLER.—On October 6th, at 1, Dudley Road, Hastings, the wife of F. J. Cutler, M.R.C.S., of a daughter (stillborn).

Ed.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

VISCOUNT KNUTSFORD'S dramatic announcement last week has again focussed public attention on the precarious financial position of those General Hospitals which depend for their revenue upon voluntary contributions. Although Lord Knutsford, probably intentionally, somewhat overstated the case, the position at the London Hospital is sufficiently serious in spite of the fact that all the patients who can afford to do so are paying something towards their keep; indeed, most hospitals are now recognising that the principle of patients' payments, which has recently been recommended by the London Committee of the British Hospitals Association, must be adopted in one form or another. St. George's are now making a charge of from 10s. 6d.—£3 3s. a week to all in-patients and of 6d.—2s. a week to out-patients. A similar arrangement has also been made at King's College Hospital.

But evidently the income derived from patients' payments will never be sufficient to meet the excess of expenditure over income—an excess which, in all hospitals, has been increasing by startling proportions in the last few years. A correspondent in the *Daily Chronicle* has stated that the total debit balance for all the London Hospitals for the last financial year is no less a sum than £750,000. He (or she) asserts that a levy of twopence per week upon all insured persons in the County of London would raise a million a year, and suggests that this might be done by raising the contributions of insured persons and their employers by one penny a week each. This sounds an attractive idea, and the principle might possibly be adopted, but not before certain rather fundamental reforms have been made. Lord Knutsford has pointed out that at the London Hospital there is a long waiting list of patients seeking admission, whereas, a few hundred yards away, the infirmary has 200 empty beds. The insured person would have something to say if, after contributing to the maintenance of the voluntary hospitals, he himself was sent, when ill, to the infirmary. Even now hundreds prefer to stay at home rather than go to the infirmary. Until radical changes have been made in the administration of the Poor Law such a scheme appears impossible.

We have once before referred to the argument that state contributions inhibit the voluntary subscriber and we suggested a method by which such inhibition could be avoided—namely by the state contributing a proportion of the amount voluntarily subscribed. The large employers of labour mostly contribute to one or more hospitals, but if they were contributing under

compulsion on behalf of their insured employees they would probably not feel inclined to subscribe to an individual hospital as well.

Whatever method may eventually be decided it seems clear that it is quite impossible to rely solely on voluntary subscriptions and donations. There can hardly ever have been an appeal for money more widely advertised, more skilfully conducted or more deserving of support than the recent appeal on behalf of St. Bartholomew's Hospital. And what was the result? £132,000 was raised. The Hospital costs £160,000 a year to run so that the annual need of the Hospital is £30,000 more than the sum subscribed. The result clearly demonstrates that the Hospitals cannot depend upon the generosity of the public for the enormous incomes that they require and that an alternative method must be found, and found soon.

Residents, and those who aspire to become Residents, will be glad to hear that Dr. Waldo, the City and Southwark Coroner, has been drawing attention once more to the inadequacy of the fees allowed under the Coroner's Act. Admittedly it is a great injustice that two guineas is paid to a resident for making a post-mortem examination and giving evidence on a "B.I.D.," whereas he gets nothing if the patient dies after passing the doors of the Surgery. The *Medical Press and Circular* for October 28th draws attention to the fact that in Australia a fee of two guineas is always allowed whenever a coroner directs that a post-mortem examination should be made.

Efforts have been made in the past to remedy this state of affairs, but the ratepayer, out of whose pocket the costs of Coroners' Courts are taken, has always been considered of more importance than the doctor. Dr. Waldo has sent us some interesting facts with regard to the history of this controversy in which he has interested himself for many years. As long ago as 1908, when giving evidence before a Home Office committee, he recommended that all qualified medical men ought to be paid £2 2s. for an autopsy and £1 1s. for giving evidence. The committee produced a report in 1910, recommending this change, and a Coroners' Bill, incorporating the suggested reform, was read, but Parliament could not find time to introduce it. Dr. Waldo's suggestion now is that hospital doctors should canvas their M.P.s. Unfortunately we rather doubt whether Residents, except those with University votes, ever get on the register, and a constituent without a vote is not likely to have much influence with an M.P. But there are several M.P.s and one member of the Upper House who have themselves been Residents at Hospitals. Perhaps they might be induced to take up the question.

It has been confessed by many competent observers, not themselves Guy's men, that the Gordon Museum has few equals the world over. This being the case we hope it will not be allowed to fall into neglect and that active steps will be taken to improve it and to keep it up to date.

The labour and expense involved in maintaining a museum are very considerable, but these difficulties can in a large measure be met by doing gradually what it would be impossible to do in a short space of time. Now that colour preservation by the Kaiserling method is so satisfactory it would surely be a good thing to replace, bit by bit, all the specimens in which the original colours are at all valuable. Many a specimen seen at autopsy is quite unrecognisable after having been "pickled" for 10 years: and some of the specimens at present in the museum are 80 years old or more. One reverences them as relics of an immortal past but many of them have little value for demonstrating

the finer points of morbid anatomy. We would not suggest that Bright's original Kidneys or Addison's Suprarenals should be destroyed; but they are mere curiosities and, as pathological specimens, could easily be improved upon. There are some sections of lungs, for example, which differ little in appearance from a plain sheet of white paper.

Photomicrography is now a comparatively easy process, and it would enormously enhance the educational value of the museum if photographs of the histological conditions of all the specimens were hung up behind each bottle. Their preparation would be a long and tedious task but surely it would be well worth while.

One of the chief features of our museum, and the one that most impresses the visitor, is the collection of wax models of anatomical dissections and skin diseases. To these latter there is not even a catalogue. Some of the cases are not labelled and, on those that are, the writing is often not easily intelligible. A descriptive catalogue of these models is very urgently needed and we hope it will not be long before one is prepared. It might also be possible from time to time to add to the collection. The art of modelling cannot have entirely died out. At any rate Madam Tussaud's is still a flourishing concern, though we are not aware if any of their celebrities have suffered from skin complaints. Possibly there may be some in the Chamber of Horrors into which we have never personally penetrated. There was recently a case of that rare condition Keratodermia Blenorrhagica in Stephen under Dr. Fawcett. A model of his feet would have been a striking addition to the collection.

THE new Clubs' Union Year Book has just appeared, and we understand that it can be had on application to the Medical School Office. Applicants should send the number of their subscribers' season ticket. It has been brought out in pocket form for the sake of convenience, and its bulk has been considerably reduced, as it no longer contains the names and addresses of all life members. It is inevitable that the Year Book should never be quite up to date, because there is no fixed time for electing officers for all the various constituent institutions, and the lists of names, therefore, are often inaccurate. But it is surprising how few errors of this sort there are in the present condition, and other mistakes are, as far as we can see, not frequent. There is something odd about the "Laws of the Game of Fives," on page 87. We have not detected any other printer's errors, but our search has not been exhaustive.

A new feature of the present volume is the inclusion of brief resumés of the activities of the various clubs for the past season. The old editions, with their dry lists of names and rules, were useful for reference, but the new arrangement provides some lighter reading which should be interesting to old Guy's men who wish to follow the fortunes of the club to which they were especially attached during their hospital days.

THE Physical Society has started late this year, but the inaugural meeting, of which an account will be found elsewhere, was very well attended and a great success. Before these lines appear the Society will have settled down to the business of the session, and will have held its first ordinary meeting—a clinical evening. An excellent programme has been arranged, and we hope the Society will be well supported by all men working in the wards. We notice that a suggestion made by Dr. Shaw in his address has been adopted, and that there is to be a joint meeting between the Physical and Physiological Societies early next year.

SISTER OUT-PATIENTS reminds us that Christmas is at hand and that the Children's

Tea requires support. Will all who would care to help this ancient and admirable institution send or take their contributions to her as soon as possible? Gifts in kind as well as in money are welcome, and Sister asks us to appeal to anyone who has a few thousand bananas or oranges to dispose of to rem mber the claims of the children of the Boro'.

We regret that we are unable to include in this number the picture of the War Memorial that we promised a fortnight ago. The process of reproducing it is occupying more time than was at first anticipated, but we hope to be able to have it ready for the next issue.

We are making an attempt to restart the custom of publishing every fortnight a list of interesting cases in the medical wards for the benefit of examination candidates and others. It has often been tried before, but has never survived more than a few months. We would especially appeal to the Medical Registrars to let us have a list of their cases each alternate Tuesday, if possible, without a reminder from us. It is really impossible for the overburdened editorial memory to remember to call for them every time, so we ask our readers to blame the Registrars and not the Editor if a list of cases is not always forthcoming.

Dr. Spurgin, a contribution from whom will shortly appear in the Gazette, asks us to enquire whether any of our readers can remember when the 2nd Rugby XV was established and who was the first Captain. Dr. Spurgin who entered here in 1868 and left in 1872, was himself captain of the 2nd XV and wonders whether he can claim the honour of having been its first captain. We hope someone will be able to enlighten him.

The Physical Society.

The inaugural meeting of the Society was held on Thursday, October 28th. Tea was served in the Wills Library, where Messrs. Grattan and Messrs. Down Bros. provided an admirable display of books and instruments. At 5.30 p.m. the meeting adjourned to the Physiological Theatre. Sir Charters Symonds took the chair and, after expressing the general regret that the Honorary President of the Society, Sir George Savage, was unable to be present as Chairman, called upon Dr. Lauriston Shaw to deliver his address. Dr. Shaw said:

"Sir Charters Symonds, Presidents, and Members of the Physical Society,—I am extremely grateful for the honour that you have done me in asking me to come here tonight, and it gives me pleasure to do so because I know that you are successfully struggling from a difficult time into a time of greater ease. Although I understand you have at Guy's a record entry of first-year and other junior students, yet the number of senior men in the wards is still as a result of the war very small, and it is upon these that the burden of reviving the Physical Society rests. Therefore I am sure that you would wish me to extend congratulations to the permanent officials on the great success which attended their efforts last session, the first after the war. I recognise that we are not yet quite on the old lines, because this first meeting is taking place on October 28th, and it was not until the session was already advanced that I received the flattering invitation to perform this responsible duty. I mention this as an excuse for defects in my address that are due to unpreparedness, also that I may make an earnest appeal on behalf of the Presidents and Secretaries that you, this large attendance here, will snow the Secretaries under with offers to read papers and open discussions, that you will come in by tens and scores to take part in these discussions, and will bring a constant supply of specimens and cases to the clinical and pathological evenings.

"These opening meetings are not generally used chiefly for propaganda, but more usefully for the purpose of reflection.

Looking into the Future.

"We use the mirror to see what we are up to and whether we are up to it. And, having a mirror in our hands, we may fix it at various angles. Like a motor driver, we may use it to glance on the road we have already travelled, or we may use it periscopically to see what other similar Societies are doing and what we may learn from their work. Lastly, we can put the mirror in the laryngoscopic position, and try and look into the future and see what lies in store for us in order to prepare our-

selves for the difficulties and troubles ahead. Sir William Hale-White, at a similar meeting last year, gave a most valuable and inspiring address upon the past history of the Physical Society. He gave you a great deal of interesting information about the people that took part in founding it. My intention to-day is to put the mirror in the laryngoscopic position and help those of you who care to look over my shoulder to see into the future and make provision for the work that lies before you.

THE OBJECTS OF THE PHYSICAL SOCIETY.

"I am not sure whether Sir William Hale-White in his retrospect gave you a complete list of the ancient rules of the Physical Society. You know how such rules usually begin. 'That the name of the Society shall be X, and the objects shall be —whatever they shall be.' I do not know whether there is a rule extant as to the objects of the Students' Physical Society, but I will venture to frame one. The object of the Pupils' Physical Society should be to enable the pupils of Guy's Hospital to take an active part in securing the aim of the great profession that they have joined, both during the five years that they are officially students and when after they are qualified they enter on their life-long studentship as medical practitioners. To make this rule complete I must define the aim of the Medical Profession.

OUR PROFESSIONAL AIM.

"The three-fold aim of the medical profession is to make, to spread, and to use medical knowledge —to make it so truly, to spread it so widely, and to use it so wisely, that no preventible disease shall be unprevented, no curable disease shall be uncured, and no relievable suffering shall be unrelieved. That is a high aim, and all the more gladly will the Pupils' Physical Society help to secure it. What, however, I would like you to feel is that this high aim is not peculiar to medicine. All honourable human vocations have as their aim the making, spreading and using of the knowledge upon which they depend. At the Introductory Lectures given us when I was a student too much was made of the noble and altruistic work that we had undertaken in joining the profession. I cannot help thinking that this stress led us as medical men to a false sense of superiority, and blindness to that form of vision which Burns regarded as peculiarly useful in freeing us from foolish notions. I would rather have you think that most of the problems that we have to solve in order that we may secure our aims are really world problems. At any rate, to-day I should like to suggest to you that the chief problems ahead of the profession are due to inevitable difficulties which result from the inevitable world movements for the sub-division of labour and the specialisation of function. I say an inevitable movement, for human progress cannot occur without a sub-division of labour, but I lay stress on the fact that this sub-division creats inevitable difficulties. The movement, the resulting difficulties, and the effort to overcome them are all world wide. You see an attempt to overcome the difficulties resulting from the division into separate nationalities by forming a League of Nations, the difficulties which come from the division into producer and consumer, by the attempt to nationalise industries, and the difficulties which come from the division into employers and employees by efforts at co-partnership, guild-socialism, etc.

RESEARCH, EDUCATION, PRACTICE.

"What are these divisions, these sub-divisions of labour and specialisation of function which, inevitable in medicine will, if not properly safeguarded, interfere with our aim? The first line of cleavage is that which I used in defining the aim of the profession as making, spreading and using knowledge—research, education and practice. It has been one of the especial privileges of medical education, one for which other faculties have envied us, that we have been able to attract as teachers the most prominent practitioners in the profession. Engineers bemoan that they cannot get as professors the men that make an Assouan Dam or a Forth Bridge. Faculties of Divinity regret that they cannot get an Archbishop or Bishop to become a teacher in their colleges. Schools of Economics regret that they cannot get the great masters of commerce to come and teach their pupils. We have been able hitherto to secure that those men that are prominent in practice shall be available for the purposes of education. It has usually been the case that these men have been the means of making the most valuable advances of knowledge. For some years now, however, there has been an attempt to segregate the makers of knowledge and to call them Researchers with a capital R. It is said that these men having special gifts should be relieved of the irksomeness of teaching and the drudgery of practice. I believe this is due to a misconception as to research. It is thought that research is a rare gift which can, however, be encouraged by isolation. I doubt it. I think, as a matter of fact, the power of research, that is the power of investigation, careful observation and truthful record, really exists in all of us, but that gradually, by wrong methods of education, it is crushed out of us. But it is not destroyed, only arrested; and it is important for us to realise that it is not desirable, in order to secure our high professional aim, that we should thrust upon a small select company the making of our research, but should instead by proper arrangements in our medical schools and proper professional

organisation see to it that every student and every practitioner is afforded time and opportunity to take some share in the inspiring duty of adding to medical knowledge in association with his other work, whatever that may be.

Whole-Time Professors of Medicine.

"Recently there has come a further development. Recognising the futility or inopportuneness of preventing a researcher from having any duties as a teacher, a proposal has been made that the researcher and teacher as one person shall be segregated from all duties in the way of practice. This proposal is put forward as a means of improving the conditions of teaching and research, but it is really, though perhaps unconsciously, an attempt to overcome an economic fault which should be overcome in a different way. The remuneration of research and teaching has become so exiguous that it has been impossible to secure that those that are engaged in practice shall also give adequate time to the practically unpaid duties of research and education. Our scheme of remuneration must be modified so that we may adopt as a general principle that every researcher should spend some time in education and practice, every teacher should spend some time in practice and in research, and every practitioner should spend some time in spreading and making knowledge. To certain men may be delegated primarily the duty of research, to others primarily the duty of education, and to still others primarily the duty of practice, but I am convinced that it will improve the work of all of them if we encourage and require those that are primarily engaged in one direction to be also engaged to a certain extent in both of the others. Some of you may recently have seen advertisements of other medical schools in which a great deal has been made of the fact that these schools have set aside one or two chief teachers of medicine or surgery to be whole-time professors; men who will do nothing else but teach and research.

The Unit System.

"You may have wondered that this great scheme was not being carried out at Guy's. It is because I think your staff have seen what they think was a more excellent plan, and felt that this segregation of one or two of their number to undertake teaching and research by abandoning practice must have a deleterious effect upon the others. It must give to the others a suggestion that they are not expected to teach or to advance knowledge. The School has decided that within the limits of capacity every member of the staff should have opportunities of, and assistance in, both teaching and research. Thus every surgeon and physician has attached to him three qualified men, each primarily employed in one branch of our professional aim. First a medical or surgical assistant whose chief function it is to assist the physician or surgeon in the research work of his department, second a registrar to assist in education, and third a house physician or house surgeon whose chief function it is to assist him in practice. By this means the student, who has always in Great Britain been regarded as doing his most important educational work by assisting the member of the staff to whom he is attached in the treatment of patients, will also have the opportunity of assisting in the duty of advancing knowledge.

Youth and Age.

"Before I complete my review of the scheme as I understand it at Guy's, I should like to draw your attention to another line of cleavage in function which comes from age—the differentiation in work resulting from the judgment and experience of age and the receptivity and enthusiasm of youth. The greatest privilege that I had as a physician at Guy's was that on every occasion of a visit there I was able to mix my brains with the brilliant young brains of the students working under me. When, for example, going around a ward I came upon a critical student who refused to receive without comment the facts that I was trying to instil, I was learning as well as teaching. But I did not have what I think I ought to have had, the opportunity of constantly mixing my brains as an assistant physician with my senior physician's brains and as a senior physician with my assistant physician's. As a senior physician my junior came into the wards when I went out, and, vice versa. My relations with my senior and junior physicians have been most cordial and to me most agreeable, but we had no work to do together. In that respect I think there was a failure to avoid the cleavage which results from this natural division of age and youth. Now under the new unit system, which I am describing, an atttempt is being made to co-ordinate more closely the work of the junior and senior members of the staff. The students appointed to them are attached to them jointly and not individually. It is proposed that they should undertake jointly the ward and out-patient work. I may be asked is this new scheme a success? I am bound to say from criticisms that I have heard that it is not working as vigorously as some of its promoters would have wished. A great change of this kind would naturally take some time in getting into full working order. I venture to suggest that for the perfect working of the unit system it is essential that there should be, beyond the mere formal meetings of individuals in their work, periodic meetings of all the members of the firm of a more or less informal character in order that they may discuss together future procedure in each of the three branches of their work.

THE ANCILLARY SCIENCES.

"I now come to another line of cleavage which is a direct result of the advancement of knowledge in the ancillary sciences with which medicine commences. When I first came to Guy's a physician was lecturing on physiology, and two of the surgeons were lecturing on anatomy. As soon as I had finished my official five years' studentship at Guy's I taught biology. All that is now passed, and one of the last official acts that I remember to have performed while still senior physician here and Chairman of the Reconstruction Committee was to convey to the Medical School a proposal that the ancient system whereby the surgeons gave lectures in anatomy should be abolished and a full-time professor of anatomy should be appointed. Now we have reached the stage in which all the early sciences are taught by specialists, and physicians and surgeons do not attempt officially to teach physiology and anatomy. Both the old and the new plan have their disadvantages as well as their advantages. In the old days while the physician was in the physiology laboratory he had his mind constantly turned to the problems which he was trying to investigate in his wards, and was therefore likely to draw the interest of his students to the practical application of physiology to medicine. On the other hand, the teacher of physiology going around the medical wards with the student he had already taught expected that student to know some physiology and found it easy to interest him in the practical application of physiology to pathological problems. But the disadvantages outweighed these advantages. On the other hand the disadvantages of the present system are that the student in the wards is too much divorced from his earlier studies. When he passes from the dissecting room into the wards he shakes off his anatomy and physiology from him. Attempts are therefore being made to try and overcome the disadvantages which occur from this cleavage. When I was an examiner in medicine we used to try and overcome it by asking one question in medical anatomy at the finals. It meant that I had to look up the big Gray before I could set the question, and probably the student spent two evenings looking up his pocket Gray to prepare to answer it. It was not really a very successful way of meeting the difficulty. I am not sure that the difficulty can be met. The Reconstruction Committee did suggest some ways of overcoming it. One way was that there should be special courses delivered by the physiologists and anatomists from time to time to the men in the wards, trying to interest them in points in which their special sciences might help them, or should be helping them, to solve the everyday problems that they were meeting in the wards. Some such proposal might well be tried, if not with the certainty of success at any rate with the hope. Another proposal that has been carried out is that in every firm on the clinical side one of the junior staff shall not only be a person engaged in work in the ward, but also shall be part-time engaged in some work in one of the laboratories of the earlier sciences, making him a liaison officer, so that the physician having a problem that could be referred to the anatomical, physiological, biological or chemical department for solution would have this officer at hand ready to keep these departments in correlation with the wards. I have now pointed out three important lines of cleavage and indicated some of the means of meeting the difficulties they entail.

PREVENTIVE AND CURATIVE MEDICINE.

"In the later stages of our work there are many other specialisations of professional function which uncontrolled must seriously handicap us in securing our high aim. I will merely enumerate a few of them. There is first of all the differentiation between preventive and curative medicine. In many quarters this has come to be regarded as a primary and essential cleavage in our professional activities, and it has been thought to be a reasonable proceeding that medical men should be definitely divided into those who try to cure and those who try to prevent disease, each section restricting itself to one or other of these efforts. But this is indeed a 'foolish notion,' and one that must be resisted with all our might. It is clearly the duty of every practitioner, whenever a patient presents himself suffering from disease of whatever nature, to take every possible step whilst trying to cure it to ensure that its recurrence shall be prevented. If it is an infectious or contagious disease it is equally his duty to take all necessary steps to prevent the disease spreading to those around. This has always been his duty, and will always remain so, and to suggest for a moment that a medical practitioner should cast this responsibility upon any other class of his colleagues is a hopelessly retrograde step. For large classes of disease the most efficient method of prevention is rapid and perfect cure, so that it is equally impossible to contemplate a class of 'preventive practitioner' who is not fully competent to treat any form of illness with which he may come in contact. This is a form of sub-division so undesirable that we can only meet it with a direct negative.

COMMUNAL AND INDIVIDUAL MEDICINE.

"There is, however, a line of cleavage having some superficial resemblance to this, from which we cannot escape, and which properly safeguarded will surely prove beneficial. I refer to the division of function between those medical men who deal with the ill-health of the people as a crowd and those who deal with ill-health in the individual.

the one acting through legal orders and by means of compulsory powers, the other by personal influence and persuasion. When it first began to dawn on us that people could be made healthy, or at any rate less unhealthy, by Acts of Parliament, certain duties in connection with these Acts were entrusted to local medical practitioners. By degrees a specialised class of medical men—Medical Officers of Health—has been set aside for this work, and it is generally coming to be recognised that a complete separation of function between these officers and medical practitioners will best assist the aim of the medical profession. This separation of function must, of course, be accompanied by the closest co-operation between the two classes of medical men; complete separation will indeed be found to be the best means of promoting co-operation.

MEDICINE SPECIALISM AND SEPARATISM.

"The most complicated and confusing differentiation of function in medical practice comes from the constantly increasing number of 'Specialisms' into which medicine and surgery are being gradually sub-divided. Restricted to four or five when I first entered medicine, they are now so numerous that time will not permit me even to enumerate them. Men are regarded as, or claim to be, specialists in diseases affecting different parts of the body or affecting persons of different ages or sex, or to be specialists in the use of certain instruments for the diagnosis or treatment of disease. They may specialise again in diseases produced in a particular way or even by a particular micro-organism. I can neither enumerate all the specialisms nor even the principles, if such they should be called, on which specialisms are based. The impossibility of a patient deciding to what specialist he should apply for relief, and the possibility of his being and remaining under treatment by three or four specialists at the same time for the same or different diseases, are sufficient indication of the difficulties that beset us from this minute sub-division of labour. Lastly, we have a fundamental sub-division into the general practitioner and consultant, in which the differentiation is so incomplete that most general practitioners act from time to time as consultants and all but a small minority of consultants undertake independent practice. For the overcoming of the difficulties thus produced I believe it will be necessary for the profession to adopt in some form the principle of 'separation' which has long existed in the legal profession as the basis of the relation between barristers and solicitors.

THE ROLE OF THE PHYSICAL SOCIETY.

"And now I must tell you of certain ways in which the Physical Society may be the means of assisting in the efforts being made at Guy's to lessen some of the difficulties which I dealt with earlier this evening. First I think the Physical Society might well become the connecting link between the various firms organised on the unit system. The exigencies of time and space make it impossible for each of you to be attached to all the units during your course at Guy's. When a teacher in one of the units tells you that the views of a teacher in another unit are all 'tommy rot,' students from these respective units will be able at meetings of the Society to compare and contrast these conflicting views. On pathological evenings it may be possible for you to bring before the Society specimens resulting from the putting into practice of the views of your respective chiefs. If one unit succeeds in making a definite contribution to medical knowledge, the Physical Society will be the most appropriate medium whereby this knowledge may speedily be spread throughout the Hospital.

"The Physical Society may well also be a valuable connecting link between the earlier and later periods of study. When I was a student men in the dissecting room used to read papers on two or three evenings each session on physiological, chemical or anatomical subjects. Now you have a flourishing Physiological Society, and I suggest to you it would be a good plan that one or two of your meetings each session should be joint meetings with this Society to discuss subjects where physiological and pathological questions have a combined bearing on clinical problems. Such joint meetings of different sections have been a useful feature of the work of the Royal Society of Medicine and of the British Association.

"Until London medical students are wise enough to form a Students' Union to further their interests and bring their views on medical education and reconstruction before the examination authorities the Physical Society might well be the means whereby after discussion the students of Guy's might make their views on these subjects known to the teachers in their own School. From my experience as a teacher I am sure these views would be warmly welcomed by those mainly responsible for the directing of education.

"Lastly, the Physical Society may take a very important part in helping the profession to gain its great aim if it teaches all its members to speak in public. The gift of public speaking is so valuable in enabling men with ideas to take a useful part in social work of all kinds, that much as I resent the prospect of adding any additional compulsory subject to the medical curriculum I would almost make an exception in its favour. It would be a good thing if the student when he comes up to the examination hall should be required to address the examiners. If everybody could speak well in public there would, I believe, be much less public speaking and more public doing. At present

speakers are rare, and this gives too much opportunity and power to the man with the big voice and the little brain. I thank you for listening to me so patiently, I congratulate you on being active members of this ancient Society with its splendid traditions, I confidently exhort you to see to it that these traditions are worthily maintained (loud applause)."

The Chairman (Sir Charters J. Symonds) said: "Your applause makes it hardly necessary for me to propose a vote of thanks to Dr. Lauriston Shaw for his stimulating and interesting address, which I am sure that you have all listened to with great pleasure. I hope we shall see it, as we saw last year's address, in the GAZETTE. I would like to reiterate his congratulations to those that have become members of this very ancient Society, and to hope that in your hands the traditions will be well and worthily upheld. I can go back to the time I first became a member, and how difficult it was to open one's mouth on those occasions. I also had the pleasure of receiving the Physical Society prize in my particular year, and I only yesterday used the stethoscope that I bought with the prize money. I should like to thank you for the great honour that you have done me in again electing me a vice-president of the Society. Having been its secretary for several years, I appreciate this all the more because I have never lost my attachment to the Society. I am proud to belong to it, the oldest Medical Society in London. In conclusion, let me express the great pleasure it has given me to come here to-night. I am sure the presidents will be glad at the large attendance, especially the large number of the staff present (applause)."

After a hearty vote of thanks had been accorded to the Chairman, the meeting adjourned.

It takes a large company to fill the Physiological Theatre and there were plenty of vacant seats. But there were over 100 present, including many members of the staff, and the Society has every reason to be satisfied with so good an attendance at the first meeting of the session. Now that such an excellent start has been made it is to be hoped that the precedent set will be maintained at future meetings throughout the winter.

Programme for the Session 1920-1921.

Nov. 11th. Clinical Meeting. Chairman, Mr. W. W. Payne.

Nov. 18th. Demonstration of Pathological Specimens and other communications. Chairman, Mr. A. H. Douthwaite.

Nov. 25th. Clinical Meeting. Chairman, Mr. E. A. Leviseur.

Dec. 2nd. Paper by Mr. M. H. MacKeith "Reflex Phenomena in Man." Chairman, Mr. L. K. Watson.

Dec. 16th. Clinical Meeting. Chairman, Mr. G. Massie.

Jan. 6th. Combined meeting of the Physical and Physiological Societies. Discussion: "The function of the liver in relation to disease." Chairman, Mr. A. T. Rogers.

Jan. 20th. Clinical Meeting. Chairman, Mr. C. Gill Carey.

Feb. 3rd. Paper by Mr. M. E. Shaw, "Athlete's Heart." Chairman, Mr. W. Mark Brown.

Feb. 17th. Demonstration of Pathological Specimens and other communications. Chairman, Mr. D. J. P. O'Meara.

Mar. 3rd. Clinical Meeting. Chairman, Mr. R. J. Hodgkinson.

Mar. 17th. Paper by Mr. B. L. Laver. Chairman, Mr. M. Coburn.

Mar. 31st. The Treasurer's Prize Essay.

Members are reminded of the three prizes which are given annually, and of which full particulars can be found in the Clubs' Union Year Book. The subject for the Treasurer's Prize Essay this year will be "The value and results of splenectomy excluding removal of the viscus for injury."

The conditions and rules governing the Essay will be found on pages 69 and 70 of the newly published Year Book. Intending competitors are reminded that all essays must be sent in by February 28th, 1921.

G. B. DOWLING.
J. G. GAYMER-JONES.
Hon. Secretaries.

Papers by Guy's Men.

H. E. Marsh, M.C., L.D.S., D.D.S.Penn., Total Calcification of Pulp Canal following a Blow in a Boy aged 17.—*British Dental Journal*, November 1st, 1920, p.1,019.

A. H. Tubby, C.B., C.M.G., M.S., F.R.C.S., Orthopædic Surgery.—*Practitioner*, November, 1920.

Change of Address.

Charles Spurrell, from Poplar & Stepney Sick Asylum to St. Andrew's Hospital, Devons Road, Bow, E.3.

D. H. A. Galbraith, from Poplar & Stepney Sick Asylum to The Walk, Launceston, Cornwall.

W. L. Gwyn Davies, High Wood Hospital, Brentwood, Essex.

Bacteriological Cleanliness in Daily Life

[COMMUNICATED.]

It took surgeons some time to recognise the bearing of the discovery of micro-organisms on their daily work. When once they overcame their surprise at the teaching of Lister they fell to with zeal, and the benefit to the human race has been incalculable. Much still remains to be done before man obtains full benefit from his knowledge of the almost universal presence and deleterious results of maleficent germs. The medical profession can claim little credit for endeavouring to impress upon the public in any detailed form the benefits that would accrue from strict observance of that section of personal hygiene which consists in banishing evil microbes from places were they tend to lurk.

The fact that carriers of germs whose normal habitat is the intestine are liable to cause infection to large numbers of others *if they happen to be cooks* should give one furiously to think. Has the medical profession, have the Medical Officers of Health, have the Ministry of Health done anything to inculcate in the public the habit of cleanliness in connection with the act of defæcation? Is any attempt being made in the Ministry of Health's housing scheme to introduce a wash-basin into every water closet? Does anyone remember to have seen in the houses of the rich a wash-basin in connection with the water closet set apart for the servants of the establishment? The present writer, visiting last year one of the colleges of the most aristocratic University of the world, was shocked to note that in a block of urinals and water closets recently erected no provision whatever was made for washing. In water closets in some houses a towel is hung. What for? Is it a recognition that the fingers may be soiled? Is a dry towel an adequate means of purification?

This is an unpleasant subject, but medical men must shirk no educational work that tends to health and a hospital journal read by students and nurses is an appropriate medium to ventilate the question.

So obnoxious do some surgeons regard the micro-organisms that live in the colon that they cut out people's colons in order to restrict the germs' activities. But what is being done to educate the public to the danger of these micro-organisms being carried to other parts of the body and to other people?

The extremely prevalent complaint, pruritus ani, is undoubtedly due to the irritation of the skin and external mucous membrane by fæcal material. Is the medical profession teaching the public that this contamination cannot possibly be prevented by the common use of dry paper? In the East a bowl of water is a marked feature of the toilet of defæcation. Adequate cleanliness is impossible unless a wash-basin is provided in the water closet. Are in-patients in hospitals instructed in the toilet of defæcation? When confined to bed are they provided with adequate apparatus? Are hand basins brought to them immediately after the use of the bed-pan?

It is well known to the profession that the number of women suffering from bacillus coli infection of the urinary tract is enormously greater than the number of men. The reason for this is clearly based on anatomy. Is any attempt being made to instruct women as to the simple measures that should be taken to avoid infection?

The prevention of thread worms in children depends on a similar educational crusade.

It is unfortunate that the Ministry of Health has been entrusted with the duty of dealing with housing as a whole instead of with the strictly health aspects of the problem. Harassed by almost insuperable difficulties in connection with labour and finance, it is impossible for the Ministry to give attention to such details as are here suggested. With more time at their disposal the Ministry might turn its attention to the prevention of the wholesale transfer of obnoxious microbes from dust collecting carts to the contents of vans delivering open tarts to the tea shops of refreshment contractors. Two such carts may often be seen drawn up by the pavement end to end, and as the dustman empties the noisome contents of his basket into his cart a strong wind may carry much of it on to the trays of delicacies in the adjacent van.

To return to more personal matters, there is urgent need of inculcating bacteriological cleanliness in connection with the sexual act. Subsequent ablution should be the invariable habit. Many minor ailments and discomforts would be avoided. Is not this indeed the basis of the propaganda of the Society for the Prevention of Venereal Disease? The teaching should have come long ago, as soon as the deleterious effects of micro-organisms were recognised. But in this matter the profession has been dilatory. True, much has been done to attacks germs when they have obtained lodgment in the human body. Attempts are made to raise the patient's power of resistance by injections of vaccines and anti-sera, and patients have been warned and duly alarmed as to the invasion of their bodies by all sorts of foreign germs from other persons. It is time we warned them to take care that the germs that they are bound to harbour or come in contact with in living their own lives and procreating their species should be simply and safely dealt with. These are

not matters that can be shouted from the house-tops, but medical men and nurses can do much to educate those with whom they come in contact, and parents properly instructed can hand on the knowledge to their children.

The only recent public pronouncement on bacteriological cleanliness in daily life the present writer can remember was made some years ago by an eminent bacteriologist, who, at a British Association meeting or on some such well-advertised occasion, warned the public against too frequent ablutions, lest thereby they should lose the immunity which comes from repeated infection by noxious germs. The press did not know whether to take the eminent man seriously or not. The public did not need his warning. The profession has not yet taught us to be bacteriologically clean.

Clinical Demonstration at Lambeth Infirmary.

Neurofibromatosis (molluscum fibrosum—Von Recklinghausen's disease).—Christina C., æt. 22. Patient presents the typical multiple soft fibromata; in places the tumours are very vascular and in others pigmented.

Fanny B., æt. 68. Patient presents typical multiple soft fibromata; some are pedunculated, some sessile, many are pigmented and there are patches of pigmented skin not associated with tumours. The distribution is universal, and no situation particularly favoured. The patient has torticollis of recent development, and it is possible that this is due to an intra-vertebral fibroma. She has had a hemiplegia recently, due to cerebral thrombosis.

Osteitis Deformans.—Mary Ann C., æt. 84. No history obtainable. The patient's skull and spine show the condition that is typical of advanced osteitis deformans; no other bones are affected. Patient is completely deaf owing to involvement of the internal ear. The radiograph shows immense spongy thickening of the cranial vault.

John R., æt. 70. In August, 1920, patient noticed a small soft swelling on his head. This gradually increased in size and became ulcerated. Since then similar swellings have appeared on his head and elsewhere. Some of them have healed up after ulceration. He has not noticed any increase in the size of his head. The patient now presents a large ulcerated mass on the right side of the skull. There are many small tumours on the head, one on the inner side of the left arm and one in the post axillary line. Radiograph shows thickening of the skull typical of osteitis deformans. No other bones show the deformity usual in the disease, but the patient has much kyphosis and marked rigidity of his spine and unusually thick clavicles.

Phyllis P., æt. 88. Patient has senile dementia, and her history is unreliable. Her relations say that they have not any cases of similar deformity in the family. She has eight healthy children living. Both patient's tibiæ show the typical enlargement and deformity. No other bones show the changes characteristic of the disease. Radiograph shows the tibia to be greatly thickened. In places the compact bone is becoming spongy. Note calcareous arteries in the plate. The patient, in addition to osteitis deformans of tibiæ, has a typical senile kyphosis and a small exostosis of left humerus. She is very deaf, but the radiograph of the skull does not show any sign of osteitis. The Wassermann re-action is negative.

George Frederick J., æt. 72. Patient's bones have been getting bigger for nearly twenty years. He has been deaf for 13 years. He presents the typical deformities in all the bones. He can walk with difficulty owing to the deformities. Radiographs show thick spongy bones and calcified arteries.

Paralysis Agitans.—Jane L., æt. 50. Patient's illness started with tremor and weakness of the left side of the body in 1913, and since then she has got progressively worse. She exhibits the typical Parkinsonian expressionless face, pill-rolling tremor, adduction of shoulders, rigidity of limbs and festinant gait.

Dry Gangrene occurring in a syphilitic subject.—Matilda R., æt. 82. Ulceration of left leg below knee 30 years. Three years ago the toes became gangrenous; these the patient herself amputated with a pair of scissors. Shortly afterwards a large part of the foot separated as a slough. Extensive scarring of leg. Stump ulcerated. Long bones of leg thickened, particularly the fibula. X-rays shows considerable periostitis of fibula with rarefaction. Wassermann reaction positive, and patient has internal ear deafness.

Carcinoma of Ethmoid.—Walter James S., æt. 10. Illness started with "watery nose" and headache in September, 1919. He had an operation, but immediate recurrence took place. The tumour is of unusual size; secondary hæmorrhage has occurred from a nasal polyp, but no other catastrophies have occurred.

Achondroplasia.—Jane D., æt. 56. Patient exhibits the typical features of the disease. The trunk and head are of normal size, although the head shows the shape often seen in rickets. The limbs are short and curved; the fingers short and nearly of the same length; intelligence is poor. Radio-

graphs show short curved shafts and irregularly thickened epiphysises.

Tubercle of Knee in a Syphilitic Patient.—Esther G., æt. 49. First seen five years ago with a cold abscess connected with tubercular disease of the scapula. In 1917 patient had syphilitic osteomyelitis of third right finger. For the last year patient has had tuberculous synovitis left knee. There is now partial ankylosis and partial dislocation of the left knee. The proximal phalanx of the third right finger has been absorbed.

Squamous Carcinoma of Breast.—Sarah O'D., æt. 84. Patient first noticed a small lump about the size of a walnut in her right breast about 11 years ago. According to her history, it was under the skin in the region of the nipple. The swelling enlarged slowly, and about five years ago it began to discharge freely a quantity of pus (?), followed by a rather profuse hæmorrhage. She has had a good deal of pain in connection with the tumour. There is a large pedunculated growth attached to skin of right breast with its centre in the region of the nipple. The surface is ulcerated and bleeds freely when interfered with. Not attached to the deeper structures of breast or the pectoral muscles. One or two small glands felt in axilla. The advance in size of the tumour is very slow. Apparently it has not enlarged very much during the last two years.

Interesting Cases in the Medical Wards

Dr. Hurst and Dr. Hunt—

Addison	6	Cerebral hæmorrhage.
,,	8	Aortic disease.
Mary	23	Specific meningitis.
,,	26	
,,	29	Anorexia nervosa.
,,	39	Cardiac failure.

Dr. Beddard and Dr. Mutch—

Stephen	15	Pulsus bigentimus.
,,	24	Cerebral thrombosis.
Esther	1	Aortic regurgitation (classical signs)
,,	6	Bronchiectasis.
,,	16	Rheumatoid arthritis.

A Guy's Mayor.

E. A. Farr, J.P., M.R.C.S.Eng., L.R.C.P.Lond., who has held the office of Medical Officer of Health for 26 years, has been elected Mayor of Andover for the ensuing year.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Glycerine.

DEAR SIR,—I have been finding out the value of *Glycerine in facial hyperæmia.* The red face—perhaps in bumps and blotches across the nose and on the cheeks—is a great grief to many, especially to the fair sex, who not only feel uncomfortable themselves but realise that their attractiveness is diminished.

Mrs. ———, age 30, had an extremely red blotchy face, which ill matched her delicate features. A piece of lint or linen soaked in glycerine and big enough to lie across the bridge of the nose and over on to each cheek at bedtime gradually but effectually reduced the inflammatory tissue by osmosis and she was quite thankful. *She had seen many doctors before she came to the Public Dispensary where I was on duty.*

Mrs. ———, age 40, has fibroid phthisis and is often in the doctor's hands. She has had injections of autogenous vaccine for the acne and erythema of her face, with the result that her face is worse rather than better. The glycerine pad has done much for her. She exclaims "To think of all the time, money, and annoyance of injections wasted, while such a simple remedy has done so much for me." Now all her friends notice the improvement, and want to know the secret.

The secret is the physiological process of osmosis. We all know how glycerine relieves a congested heavy cervix uteri. It might be used much more than it is as a household remedy. Its whiteness and cleanliness recommend it. After washing one's hands several times with more or less irritating soaps the glycerine and rosewater bottle comes as a healing balm.

A. WITHERS GREEN.

P.S.—The next best thing to glycerine is old-fashioned lard, which also travels through the skin. It was an evil day when the Apothecary began to use coal tar products as a basis for ointments. The vaselines block the way and actually cause a redness, where applied, in myself and others.

The War Memorial.

DEAR SIR,—One's attention is arrested by the announcement in Passim of the October 30th issue that £300 of the War Memorial Fund is to be allocated to the adornment of the College. There is no doubt the College needs adorning, but details are not appended as to the nature of this adornment. In the September 18th issue of the GAZETTE it is

stated that the suggestion to panel the walls of the College dining room fell through owing to the possible extension of the College, etc.

I cannot quite correlate the employment of a Memorial Fund with decoration of the College if one may, in the absence of fuller knowledge, understand "decoration" for "adornment." When a resident I supported a scheme for an additional hostel in healthier surroundings at Honor Oak for junior men, but arguments were raised against employing the Fund for such utilitarian purposes, beside the financial considerations such a scheme involved. Although the amount is a fractional one of the total Fund, it conflicts with my ideals of a memorial that any should be employed in defraying the cost of renovating or re-decorating the College premises, which should be undertaken by those responsible for the maintenance of the fabric and "up-to-date-ness" of the College.—Faithfully yours,

A. ALAN FORTY.

Oriel Cottage,
Shenington, Banbury, Oxon.
Nov. 4th, 1920.

[Personally we agree with Dr. Forty. But the money was allocated to the various purposes mentioned in the GAZETTE of October 30th by the authority of a General Meeting of subscribers, which can hardly be disregarded.—Ed., *G.H.G.*].

Guy's Hospital Reports.

DEAR MR. EDITOR,—I should like to correct a slight inaccuracy in your note to the GAZETTE last week about the New Series of Guy's Reports. We require a guarantee of four hundred subscribers, not four hundred pounds. Up to to-day we have 360 subscribers, and we assume we shall get 40 additional promises to subscribe two guineas for one year before the first number is published next January. Arrangements have now been made with the Oxford Medical Publishing Company to issue the Report, and we have already got promises of papers which should form a nucleus of four good numbers next year.

I shall be very glad if any Guy's men or others who have not already sent in their names and who are willing to subscribe, will write to me as soon as possible. I would particularly appeal to junior qualified men and senior students now at the Hospital as I have so far only had two or three promises from amongst them.—Yours sincerely,

ARTHUR F. HURST.

17, Devonshire Street,
Portland Place, W.
November 9th, 1920.

Pass List.

Conjoint Board.

FIRST EXAMINATION: CHEMISTRY, PHYSICS & BIOLOGY, September, 1920.

**H. Trafford.	‡L. R. Jones.
**H. F. Miles.	**K. G. Shervill.
L. S. Davies.	†E. Bowen Jones.
**C. H. Fox.	*R. H. Muller.
*A. R. H. Bennett.	**A. Elliott.
**A. F. Porter.	*A. A. Danino.
**W. Nicholls.	†Myer Rubenstein.
†H. Radin.	*C. F. Morrison.
‡C. L. Froehlich.	‡M. M. El. Mishad.
*C. H. C. White.	†de Ville Maingard.
**C. J. Dobbin.	**J. Luke.
†E. Sorabjee.	**T. G. Tressidder.
*E. M. Bowen.	**W. J. Hide.
**V. L. Fischer.	*H. V. R. Sellers.
**V. C. Warr.	*B. P. Jones.
†C. V. T. Baugh.	†E. A. Sheppard.
‡A. A. Arnold.	‡T. F. Fox.

**Chemistry and Physics only. ‡Biology only. †Physics only. *Chemistry only.

SECOND EXAMINATION: ANATOMY AND PHYSIOLOGY, Part I.

J. A. F. Dempster.	R. M. L. Still.
H. J. Plowright.	H. Evans.
I. E. Harries.	A. Broido.
C. H. Atkinson.	D. J. Hammond-Williams
C. W. Warne.	S. H. Daneel.

Part II., Pharmacology.

H. J. Plowright.	H. O. Eksteen.
D. A. L. Crawshaw.	V. R. de Brossiere.
C. H. Atkinson.	H. J. F. Wood.
P. G. Harvey.	M. Jackson.

Royal College of Surgeons.

FIRST PROFESSIONAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY, SEPTEMBER, 1920.

Mechanical Dentistry.

V. St. J. Alexander.	B. R. Moore.
R. C. Andrews.	F. N. Newell-Roberts.
C. C. Brattle.	F. A. Nicolai.
G. Curle.	F. R. Payne.
K. W. Eady.	Myer Rubenstein.
L. Evans.	G. Beamish.
T. F. Fox.	N. S. Campbell.
A. V. Goodson.	J. F. Allen.
L. G. Hemmings.	A. J. Britz.
M. Lewis.	J. D. Dick.
L. E. Messinier.	A. S. T. Garland.

G. G. T. Haynes.
A. H. B. Hiesom.
L. B. Helder.
W. J. Hide.
S. B. Hine.
K. Hooper.
F. G. Hutchinson.
E. J. Joels.
J. E. Jones.
J. B. Kempster.
R. V. Koenig.
A. S. Levy.
E. M. D. Mackie.
D. W. G. Northfield.
D. A. Parsons.
P. Prenaar.
J. F. Pilbeam.
H. Radin.
H. J. Raubenheimer.
J. C. Rowbotham.
W. Rowland-Hill.
W. O. Sims.
H. Slater.
J. E. B. Smith.
V. L. Sunderland.
F. W. Van der Hoven.
L. G. Ward.
F. L. Winn.

Dental Metallurgy.

V. St. J. Alexander.
D. H. Batty.
C. C. Brattle.
G. Curle.
K. W. Eady.
L. Evans.
T. F. Fox.
A. V. Goodson.
L. G. Hemmings.
M. Lewis.
L. E. Messinier.
B. R. Moore.
F. N. Newell-Roberts.
F. A. Nicolai.
Myer Rubenstein.
O. H. M. Woodbridge.
F. S. L. Barritt.
J. V. Bingay.
W. L. Boness.
T. C. Butler.
L. M. Cartwright.
H. A. Clarke.
I. G. Coutts.
F. Crone.
A. S. Davies.
R. Edwards.
H. D. Hall.
J. B. Hine.
W. V. A. Hodges.
F. A. Kerrison.
J. A. Krige.
D. H. Oliver.
S. E. Lewis.
E. H. Marshall.
R. Maxwell.
M. W. Meskin.
W. Orsmond.
F. A. Sampson.
E. G. Smallbone.
A. Tubock.
C. P. Urbani.
F. N. Van der Pant.
E. A. J. Van Hoorden.
C. A. Wakeford.
D. R. P. Walker.
C. B. Wilson.
G. Zondagh.

The Physiological Society.

A meeting of the Society was held on Thursday, November 4th, 1920, Professor Pembrey being in the chair.

Mr. Blacklidge read a paper on "The Theories of Colour Vision." On the meeting being thrown open to discussion, some original and decidedly interesting theories were expounded.

The meeting closed with a vote of thanks to the speaker and chairman.

Fifty members were present, and the good attendance is a distinctly encouraging feature.

TRISTRAM WOOLDRIDGE, Hon. Sec.

Boat Club Dance.

In spite of the fact that the Boat Club was only re-started last summer, the Inter-Hospital Rowing Cup is, for the first time in its history, already installed in the Smoking Room. It is proposed to keep it there, and, if possible, to add many other rowing trophies to it. This object, however, will only be attainable with an increase of funds other than the yearly affiliation subscriptions which are covered by a grant from the Clubs' Union.

For this purpose it is proposed to hold a dance, under the patronage of Mr. Davies-Colley (President), Sir Alfred and Lady Fripp, Mr. and Mrs. Eason, Mr. and Mrs. Rowlands, Dr. and Mrs. Fawcett, and Professor Johnston, on Thursday, December 9th, at the Wharncliffe Rooms, Great Central Hotel, Marylebone.

Mrs. Davies-Colley has kindly accepted an invitation to act as hostess.

Dancing from 9 p.m. to 2 a.m. The Swastika Syncopated Orchestra will play. Tickets, price 25s. (double, including buffet refreshments), may be obtained on application to Mr. F. C. Miller (Hon. Sec. of the Boat Club) or to Messrs. W. H. Cellier, M. E. Shaw, Lawson Brown, A. Tonn and C. H. C. Toussaint.

It is hoped that all present Guy's men will make an effort to support this latest born and already promising child.

It would be gratifying also if many of those past Guy's men who have shown such enthusiasm over the reconstruction of the Boat Club would seize this opportunity of giving their active support.

Notices.

Dr. A. H. Fison will deliver three lectures entitled "Studies from Bergson's Philosophy" on successive Thursdays, beginning on November 11th at 4.15 p.m. The lectures will probably be given in the Physiological Theatre. Provisionally the titles will be—

1. The Nature of Time.
2. The Nature of the Soul.
3. Bergson's View of Free Will.

An old Guy's man requires a partner on January 1st, 1921. Senior partner retiring. Good class non-panel practice in North London, established 35 years. Well qualified man essential, bachelor preferred. Apply for particulars to "A," c/o Editor of *Guy's Hospital Gazette*.

Case for Commentary.

I should have mentioned that in this case no article of diet could be hit upon as an explanation. The patient is an exceptionally plain liver, in fact a "chop and a steak young man." Before the last attack he had had joint meat with vegetables for some days; no honey, mackerel, shell fish, smoked fish, nor rabbit. He can take honey and eggs without any symptoms occurring.

A. PERCY ALLAN.

Books and Instruments for Sale.

The undermentioned books, the property of the late Dr. Tipping, are for sale, and may be viewed on application to the Wills Librarian, Guy's Hospital.

There are also for sale some instruments, slides and frames, dressing and midwifery bags.

Treves, "A System of Surgery," 1898, 2 vols.

Starr, "Organic and Functional Nervous Diseases," 1910, 3rd edition.

Dixon Mann, "Forensic Medicine and Toxicology," 1902, 3rd edition.

Osler, "The Principles and Practice of Medicine," 1901, 4th edition.

Waggett, "Diseases of the Nose," 1907.

Corner, "Diseases of the Male Generative Organs," 1907.

May and Worth, "Diseases of the Eye," 1906.

Muir and Ritchie, "Bacteriology," 1912, 3rd edition.

M. N. Oxford, "Handbook of Nursing," 5th edition.

Wolff-Eisner, "Clinical Immunity and Sex Diagnosis," 1911.

Hale-White, "Text-book of Pharmacology."

Jacobi, "Portfolio of Dermochrones," 1903, 2 vols.

Koplik, "Diseases of Infancy and Childhood," 1906, 2nd edition.

Trench, "An Index to Differential Diagnosis," 1912.

G. E. Herman, "Diseases of Women," 1899.

Comyns Carr and others, "National Insurance, 1912," 3rd edition.

Hutchison and Collier, "An Index of Treatment," 1908, 4th edition.

Allbutt, "A System of Medicine," 1896-1899, 8 vols.

A Case of Hydronephrosis.

Mrs. H. C., æt. 44, married, childless, was admitted into hospital on October 5th during Sir Alfred Fripp's "take-in" for abdominal pain and vomiting. She gave a history of abdominal pains, indigestion, and vomiting since the age of 10. The attacks of pain occurred at intervals varying from one to three months; they were of a colicky nature, always accompanied by vomiting, and were referred to the right hypochondriac and lumbar regions. Each attack lasted a few hours, after which she would feel perfectly well. At times she noticed a transient œdema of the feet and legs. She had always been constipated, but had noticed no abnormality of the urine.

Her symptoms increased in severity, until a fortnight before admission she was forced to take to her bed. About this time her attention was drawn to a swelling in the right abdomen. She was sent to Guy's by her doctor, and admitted into Charity ward.

On admission, in addition to the abdominal tumour, she was found to have a hard tumour in the pelvis, fixed and palpable per rectum; her urine contained a considerable amount of albumen, a little blood and mucus, and a bulky deposit of phosphates.

Sir Alfred Fripp operated on October 8th. He found a hydronephrosis, a dilated ureter, which contained an extremely large calculus, a subserous pedunculated fibroid impacted in the pelvis, and other smaller fibroids. The calculus was situated above the pelvic brim. By manipulation it was forced into the upper ureter and removed through an incision which was subsequently closed by two layers of sutures. A free channel was demonstrated along the ureter to the bladder. There was extraordinarily little change in the mucous membrane of the ureter. The urine evacuated, about a pint and a-half, was turbid and highly ammoniacal. The large fibroid was removed from the pelvis and excised together with several of the smaller ones. Drainage was established, and the wound closed.

The stone, ovoid in shape, hard, and apparently of mixed composition, measures 7 cm. in length by 3 cm. in diameter, and weighs 913 grains. Its upper, renal, extremity is coated by a thin layer of phosphate. The largest ureteric calculi quoted by Thomson Walker are 816 grains (Block), 803 grains (Carless), and 780 grains (Federoff).

It was thought that the pelvic tumour had obstructed the ureter, leading to dilatation and allowing a pre-existing renal calculus to descend. The urinary infection was probably recent, and accounted for the fine layer of phosphate.

The patient is making an uneventful recovery.

I am indebted to Sir Alfred Fripp for his kind permission to publish these notes, and to Mr. Cook who kindly supplied me with the references.

T. E. JONES.

P.S.—The patient developed acute abdominal symptoms quite suddenly after progressing favourably for a fortnight. Exploration through the old wound revealed obstruction of the ascending colon by a band. The latter was divided and the gut drained, but she died the following day. At post-mortem the kidney was in good condition and had evidently recovered its function satisfactorily. Death was entirely due to the intestinal obstruction.

T.E.J.

Reviews.

Clinical Methods. By Hutchison and Rainy, 7th edition (Messrs. Cassel & Co.) 1920.

The appearance of another edition so soon shows the well deserved popularity of this book. The student who wishes to learn or the general practitioner who wishes to keep up to date with the methods of clinical investigation could hardly find a better guide. The new features of the edition which are of most value are the plates showing malarial parasites and the fundus oculi under various conditions, and the electro-cardiogram tracings illustrating disorders of the heart. In a book which deals so well with the elementary facts of the eye and the ear and most special departments of medicine, it seems a pity that the methods of investigation of surgical and gynæcological cases should not be included. Would it be possible that the next edition should be printed on larger sheets or thinner paper, as the bulk is getting rather unmanageable?

Schafer's *Essentials of Histology.* (Messrs. Longmans, Green & Co.) eleventh edition; 14s. net.

It must be hard for a present-day medical student to conceive of the days before "Schafer." Since this work first appeared, thirty-five years ago, almost every student generation has had its own new edition as text-book and laboratory manual, slowly and inevitably growing in size, but always supreme. A medical student takes a course of histology with a two-fold aim. Firstly, to become acquainted with the relation between structure and function, and, secondly, to appreciate normal microscopic appearances sufficiently well to be able to detect and identify pathological variations. For the first purpose the study of the "experimental animal," with its, sometimes, "diagrammatic" tissues, is admirable. With regard to the second, however, we would welcome, in view of the difficulty of obtaining for class work sufficiently fresh specimens of human tissues, further illustrations of the structure of man.

Football.

GUY'S v. OXFORD UNIVERSITY.

There was a great gathering of spectators at Oxford on Wednesday, October 27th, for the above fixtures, but very little of the match could be seen, and at times the fog thickened so that it was impossible to see from one side of the ground to the other.

The 'Varsity forwards were in great form to start with, and it looked at one time as though their hard working pack would be too much for us. However, after a while our eight got going, and Marais, ever ready to snap up a chance of scoring, ran over with a try. For some time, though, after this we had to do a lot of defending, in which branch of the game all the backs proved themselves sound. Campbell and F. A. Waldock, the half-backs, got the Oxford three-quarters on the move often, but their wing men were not fast enough to beat our defence. The University handy-man, V. R. Price, played centre-threequarter, and, luckily, he rather neglected to pass, as on several occasions our rear division was a bit tied up. However, half-time found our lines intact.

The second half was a sad one for both teams, as Steyn left the field with an injury, V. H. Neser, the Oxford Blue and brother of E. E. Neser of the Hospital pack, had to retire also with a dislocated shoulder, while Olivier, our excellent full-back, broke his collar-bone. A sad chapter or sequence of accidents. The visitors were much better this second half, and Graham-Davies, after Krige and Van Schalkwijk had handled, ran in with a capital try, which the last-named converted. Graham-Davies played very finely all through, and the fog allowed one to see Albertyn and Krige doing good work. It was difficult to see in the mist which forwards were particularly good, but Doherty could anyhow be heard. The Guy's captain has never played better than this season, both his play and his leadership are invaluable. Guy's 1 goal 1 try (8 points) to nil.

Guy's team:—W. W. Olivier, P. K. Albertyn, J. A. Krige, H. Graham-Davies, S. L. Steyn, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, C. Marais, A. H. Van Zyl, A. H. Shelswell, F. J. Biddle, E. E. Neser, and R. F. H. Duncan.

GUY'S v. ROSSLYN PARK.

One came away from Richmond on Saturday, October 30th, after this match with a feeling that the Hospital should have done better. Several forwards were away, but only Steyn from the three-quarters, that is to say, only one regular playing, First XV. man, from our main attack. All were sorry to hear of Olivier's bad luck, and much hope his broken collar-bone will mend satisfactorily so that a few weeks hence he will again be able to play in the position he fills so well. Shaw did all that was necessary on Saturday. Not very much work came his way.

Before many minutes had elapsed Rosslyn Park lost Foley, a forward, who hurt his back so severely he had to be carried to the dressing rooms. Thus reduced, the Park were much handicapped. At first they tried very manfully to keep the ball from reaching our three-quarters. Luck was against them.

however, as first they suffered the loss referred to and soon after Reitz got a couple of tries. Bekker charged down the home side's full-back's kick, and Reitz being in close attendance got the try. The second he got from a line out close to the line. Neser kicked for the posts, but neither time reached the distance. Doherty played like a Trojan, and led his men magnificently. The backs had heaps of chances, but only two matured, Williams and Albertyn getting a try each, but both scores were a long way from the posts. Biddle was doing sterling work; in all the scrums his weight was most valuable. In the open, the follow up and loose work, Neser and Watson were admirable. Pity the latter cannot make himself a bit heavier. L. B. Helder looked a very promising player, and should opportunity find him a place in hard games he will improve considerably.

With 12 points to our favour and 3 to our opponents, as Trubshaw had placed an easy penalty to their credit, ends were changed. Very soon Helder was over the line, and this time Van Schalkwijk converted. Graham-Davies, who had played very finely, tried most unselfishly to get Williams in time after time, but Williams had not quite the pace to carry him over the line. He tried his utmost. Possibly the next time he plays with Graham-Davies fortune may be kinder, or he may develop that burst for the line which is so absolutely priceless. J. A. Krige looked after Albertyn to such an extent that three tries this second half fell to the wing man's credit. Krige played cleverly. Van Schalkwijk was not at his best, his kicking, especially the first half, was a lesson in strength and direction. But why kick so much? The forwards heeled; Bekker, usually prone, got the ball to his partner, who got on the move so slowly for him and dodged about without the least advantage to anyone or gaining an inch of ground. The three-quarter line of Guy's Hospital is very nearly, if not quite, the best in England to-day, but it must be served, or its cleverness is wasted. Reitz got another try this last half, and so brought his total up to three tries. Wonderful forward, Reitz, he is ever on the ball, and equally good with hands and feet. Guy's, 1 goal, 8 tries (29 points); Rosslyn Park, 1 penalty (3 points).

Guy's team:—T. A. Shaw, P. K. Albertyn, J. A. Krige, H. Graham-Davies, H. K. Williams, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, E. E. Neser, F. J. Biddle, L. K. Watson, G. Zondagh, L. B. Helder, and C. Harvey.

GUY'S "A" v. OLD BLUES "A."

This game was contested at Honor Oak Park in a thick fog, which lifted slightly several times during the game. Guy's kicked off towards the pavilion, and after 15 minutes' scrambling play the Old Blues scored through the inability of our backs to handle the ball. Guy's were the next to score, Meacock touching down after a cross kick by Cookes. Nurick improved. Following the change of ends, the Old Blues again scored as the result of a combined movement of their backs and some clever handling. Some minutes later Guy's only real three-quarter attack resulted in Weinberg crossing far out. Play now became very keen, and the visitors again scored after a forward rush well over half the length of the field. The last ten minutes saw Guy's making desperate efforts to score, but four forwards working hard cannot be expected to win through when the others lack the energy to last out the game. Ives was taken out of the pack to help the three-quarters to hold the five three-quarters always played by the visitors. If only Guy's outsides would remember that they must go down to the ball in defence when they cannot handle it with certainty. Result: Old Blues, 9 points; Guy's, 8 points.

Guy's team:—T. A. Shaw, A. S. Gough, Van der Post, L. Weinberg, H. K. Williams, L. Nurick, S. P. Meacock (capt.), G. Zondagh, L. B. Helder, P. Harvey, H. G. Close, R. V. Cookes, Ives, Hutchinson and Strong.

GUY'S "B" v. SOUTHEND "A."

Southend "A" met Guy's "B" at Honor Oak Park on October 30th, and were defeated after a pleasant game by 46 points to nil. Southend were much overweighted in the scrum, but in spite of this handicap would have done much better had they remembered the importance of tackling low. Southend were evidently put off their game by playing on a flat pitch after performing on the hilly "Priory" field. Southend's chief consolation must be in the pleasant and sporting manner in which the game was conducted—"as are all games with Guy's" (by Southend captain).

The following represented Guy's "B":—Jacobsy, Walters, McKay, Jarman, Newbery, Aung, James, Hibbins, Ives, Estment, Hankey, Wyse, Orsmond, Farris and Strong.

GUY'S "A" v. IMPERIAL SERVICE COLLEGE.

This match was played by our "A" XV. against the Imperial Service College at Windsor on the 30th October. Through some misunderstanding due to the cutting down of trains the play started fairly late. Quite early in the game Meacock scored a fine try from behind the scrum; the kick was converted by Nurick. Some time later Close managed to burst through, while the play was near their line, and scored far out; the kick being badly

placed resulted in a failure. Play was then kept in mid-field, neither side having the better. Half-time came with the result 8 to nil in our favour.

After half-time, while we held our opponents between their half and "25," one of their forwards managed to break through in the loose, was brought down near our try line, and with the support of some of his companions managed to get over, thus scoring their only unconverted try. The kick-off at once made us the offenders, and by a passing movement Gough got the ball and scored our third try, which was converted. Our forwards played well, but would persist in tackling high instead of going low; the result was that our backs had to do some unnecessary work. There were also some faults to be found with the backs, who would persist in giving the dummy too often. Sometimes the dummy was to our advantage, for Van Hurden got through on his own account by giving an extra good one to his opponent. Our forwards were fairly good at dribbling, and for this feat we got our last try, which happened after a fairly long one, and so our new recruit Amm managed to get the ball and scored. The last two tries were both converted by the stand-off half. The closing score was Guy's 23 points, Imperial Service College 3 points.

Guy's team:—S. Doniel, A. S. Gough, L. Weinberg, H. Van Hurden, E. C. Seward, S. P. Meacock (capt.), L. Nurick, H. G. Close, R. V. Cookes, R. R. Mackenzie, R. H. Amm, G. M. Stoker, F. G. Hutchinson, J. A. Currie, and L. W. Houghton.

NOMAD XV. v. GOLDSMITH'S COLLEGE.

This match was played at New Cross on November 3rd, and resulted in our defeat by 15 points to three. The game was more even than the score suggests, for we missed several comfortable chances of getting over. The forwards were rather overweighted, but played hard throughout, Cookes, Mill and Dingle being prominent. Our solitary try was the result of a forward rush towards the end of the game, Cookes touching down. The backs were disappointing, and the marking was weak against a line which should have commanded respect. Worthington and Thomas were both good in defence. The opposing pack got the ball back well, their heeling-out being especially smart.

Guy's team:—Daneel, Longhurst, Worthington, Thomas, James, Van der Post, Tran, Cookes, Hankey, Dingle, Mill, Ive, Hofmeyer, Favus and Martyn.

GUY'S "B" v. KING'S COLLEGE SCHOOL.

On Wednesday, 3rd November, an extra "B" team played King's College School First XV. on their ground at Wimbledon.

Within the first five minutes we had the misfortune to lose two valuable men, Owen and Davies, through fractures. This loss, however, seemed to spur every man on to do his utmost, with the result that we had a clean, hard-fought game. We scored first from an opening by Williams, who, on passing to Close, sent him over for a try, which Nurick converted. Soon after they broke through and scored an unconverted try. In the second part of the game play was mostly in our half, but on the only occasion we got near their line we managed to score, Close picking up the ball in the loose and falling over the line. This try we failed to convert. They retaliated by scoring a goal, and with the score eight all play settled down more or less in our "25," where only sound tackling by the backs and good kicking by Sears and Nurick made their persistent attacks abortive. In the last minute, however, they got over in a forward rush and thus won 11 points to 8 points. It was only through every man going all out that we were enabled to have the satisfaction of feeling we had kept our end up most creditably in spite of our handicap.

Guy's team:—A. S. Davies, Schollum, Owen, Gough, Sears, T. I. Williams, Nurick, Mackenzie, Hutchinson, Close, Amm, Grant, Widlake, Gross and Eckhoff.

Hockey.

GUY'S v. LONDON MENTAL HOSPITAL.

By defeating London Mental Hospital on Saturday, October 30th, by 5 goals to 1, Guy's prevailed against a strong team which had beaten them twice last year with comparative ease. Success was chiefly due to the excellent play of Hurdle at back, the untiring work of Moore at half, and the speed and accurate centreing of the two wing forwards, Owen and Hunt.

Bonnalie played centre-forward with Tonkin inside left, and, while hesitating to say that this new arrangement is superior to the old, the forwards certainly got going very well, and the scheme should be given an extended trial.

Tonkin has a good turn of speed, and combined very well with Owen in his fast runs, whilst Bonnalie was always doing the unexpected, and availed himself of the ample opportunities for clever stick work which he had in the centre. The team on the whole got going together better during this match than they have done this season, and more concentration still on combination and accurate stick work should result in a really good side. Goals were scored by Tonkin (2), Owen (1) and Bonnalie (1). Guy's team:—

Baugh, Bowen, Hurdle, Slater, Moore, Olver, Hunt, Schollum, Graham Bonnalie, Tonkin (capt.), Owen.

GUY'S v. REDHILL.

Guy's did very well to defeat Redhill on Saturday, November 6th, by 4 goals to 2, and thus maintain their unbeaten record for the season. The forwards were without L. E. Owen, who is unfortunately laid up, but Smallbone deputised well, and the whole line played a game in which the combination was the best seen this season. Hunt was good at outside right, whilst Schollum scored two fine goals, opening the scoring with a brilliant shot taken waist high. Graham Bonnalie was good at centre, scoring one goal, as did Tonkin. Moore was prominent in the half-line in stopping the good forward line of Redhill. Slater worked hard, and Bowen and Hurdle, the backs, made few mistakes. Of this match it can be truly said of Guy's that everyone pulled his weight, and victory was due to excellent team-work rather than to individual effort, and with the team going so well it was a great pity that foggy weather more or less spoilt the second half. Guy's team:—

Baugh, Bowen, Hurdle, Slater, Moore, Olver, Hunt, Schollum, Graham Bonnalie, Tonkin (capt.), and Smallbone.

Fives.

A General Meeting of the Fives Club was held on Friday, October 22nd, 1920, to elect officers and to organise the running of the Club.

Dr. Ryle occupied the chair.

The following officers were elected:—

Committee.—Messrs. W. Mark Brown, B. L. Laver, R. S. Chambers, and T. A. Shaw.

Secretary and Treasurer.—Mr. L. K. Watson.

The following proposals were suggested and adopted:—

1. That the game should be played according to Rugby Fives Rules.

2. That a book should be placed in the College Lodge in which players can write their names, and so book the court for not more than half an hour.

3. That the Committee should arrange for an Inter-Hospital Fives Competition.

4. That other Clubs should be approached with a view to arranging fixtures.

The meeting closed with a vote of thanks to Dr. Ryle for taking the chair.

GUY'S v. LONDON HOSPITAL.

On Wednesday, November 3rd, 1920, a Fives IV. from the London Hospital visited Guy's, and six games were played, resulting in a win for Guy's by 5—1 games. Results:—

B. L. Laver and R. S. Chambers (Guy's) beat I. Feldmen and L. R. Cox (London), 15—7 and 15—9.

W. M. Brown and L. K. Watson (Guy's) beat J. A. Adams and E. G. Smaith (London), 15—4 and 15—4.

I. Feldmen and L. R. Cox (London) beat W. M. Brown and L. K. Watson (Guy's), 15—4.

B. L. Laver and R. S. Chambers (Guy's) beat J. A. Adams and E. G. Smaith (London), 15—13.

Further fixtures have been arranged with Dulwich College, St. Paul's School, and Westminster School, the dates of which will be announced later.

A return match v. London Hospital will be played on December 1st at the London Hospital.

Boxing.

GUY'S HOSPITAL v. OXFORD UNIVERSITY.

This fixture took place in the Gymnasium, Oxford, on Saturday, October 23rd, resulting in a tie of three events each. Guy's secured the Bantams, Feathers and Light-Heavies; the 'Varsity were credited with the Welters, Middles and Heavies.

According to the programme there should have been a contest in the Light-weights, but the Hospital representative did not "materialise." Guy's urged that this event should go to Oxford by default, but Mr. Dove, the captain, quite naturally disclaimed a vicarious victory on the total score, and stated, at a pleasant post-pugilistic symposium, that his Club would prefer to consider the contest a draw, and hoped for a more definite result at a return meeting.

The Gymnasium was full to overflowing, not a seat in the house being left when the contest started. The referee was Lieut.-Colonel H. de R. Morgan, D.S.O., Commanding Officer of the Oxford University O.T.C., and he had as judges Major Leahy and Mr. Chandler, two whose boxing record is too well known to need recapitulation. Mr. Hammond acted as M.C., and his announcements, delivered *ore rotundo*, commanded at once attention and respect. Mr. C. B. Gull deputised as time-keeper for Mr. A. I. Walden (Sen. Treasurer), who was unfortunately unable to be present.

To get down to the boxing itself. The results were as follows:—.

Bantams.—S. P. Meacock v. H. C. Wallace (Ch. Ch.). This was a very close and well-fought contest. In the first two rounds it seemed that, barring accidents, Wallace would win, as he was making good use of both hands, and his superior

foot-work enabled him to make his opponent miss frequently. Meacock, however, was never by any means out of the picture, and his determined and aggressive methods in the final round wore Wallace down and gained him a heap of points and a well-earned victory. It was thought by many that Wallace should have received the verdict. Two of the most competent judges in England thought otherwise, and it is always well to remember that the average spectator is apt to note all the points scored by the man whom he hopes will win without taking into similar account those scored by his opponent. And, to place the matter beyond further conjecture, Mr. Wallace's *ipsissima verba* were "I was beaten by a better man." Meacock would do well to pay better attention to his foot-work, which is by no means all that it might be.

Feathers.—J. D. S. Thomas v. K. S. Shavaksha (Balliol). This bout resulted in a fully-deserved victory for Thomas. Shavaksha started off at a furious pace, forcing his opponent round the ring and getting in some telling blows, but he relied too much on swings instead of straight hits, and the frequency with which he missed must obviously have taken more strength out of him than he could afford to lose. Thomas, though he lost the first round on points, pursued the right tactics, and by clever boxing and good foot-work kept his opponent missing until in the middle of the second round it was apparent that Shavaksha had shot his bolt. Thomas then started to do the attacking, and by means of a nice straight left and some well-timed right counters, which jolted his opponent considerably, more than reduced the lead obtained by the latter in the first round. The last round found Shavaksha too tired to do much, and Thomas had no difficulty in adding still further to his lead, so that when the bell went he was a comfortable winner.

Welters.—J. N. D. O'Rafferty v. A. F. Meldrum (New College). The contest in the "Welters" was quite Homeric, and it is difficult to determine whether Meldrum would not have gained more than his narrow margin of victory if he had been content to make better use of the ring and *box* a little more. But had he done so we should not have seen half such an interesting scrap, and the Hibernian temperament of the Hospital man found one that was more than ready to reciprocate in Meldrum. Meldrum's defence was better, and mainly by means of some good right swings he managed to gain a small margin of points on each round. O'Rafferty made good use of his left, and fought stubbornly throughout. Result: a close but well-deserved victory for Oxford.

Middle-Weights.—R. F. H. Duncan v. E. J. O. Badderley (Balliol). This was perhaps the closest fight of the evening. Badderley, a newcomer into the Varsity side, showed distinctly promising form. He combined skill with speed, and effectively prevented the efforts of his opponent to get to close quarters, while he took harder punches than are apparent to the spectators with an air almost of nonchalance. The fight was interesting not only from the boxing shown therein, but also as a study in temperament. When an extra round was ordered by the referee, Badderley walked up with a cheery and confident manner simply oozing from him. Whether he *felt* it or not is another matter, but it probably helped him to gained the verdict against an opponent who was little if anything behind him in actual skill. The verdict, popularly and rightly, went in his favour.

Light-Heavies.—W. H. Summerskill v. C. P. Blacker (Balliol). We have seen some plucky winners and some plucky losers in our time, but Blacker must hold a very high place in the latter category for his exhibition on this occasion. One feels inclined to think that he was beaten more by himself than his opponent, though we would not for a moment detract from the latter's well-earned victory. Had the Oxford man been content to rely on the very capable straight left with which he gained such an advantage in the first two rounds he might have gained the verdict. As it was, he "asked for it"—and got it, but the method of giving and receiving was so clean and square that it was a pleasure to watch. Summerskill is an exceptionally strong and rugged fighter, and he could not have adopted a plan of campaign more likely to succeed than he did in the concluding round.

Heavies.—J. A. F. Dempsen v. F. S. Dove (Merton). The issue of this fight, the last of the match, was never really in doubt, though at times Dove made his supporters feel a little nervous. He seemed always to possess a store of energy, on which he appeared afraid or unwilling to draw. The first round was more or less even, while the second went to Dove by a small margin, but in the last round he landed on his opponent time and again with a series of well-timed punches which ran him up a good score of points. Dempsen possesses any amount of grit, a strong punch in either hand which might have left their mark if they had landed more frequently, and a quite good defence, but he was up against a quicker and cleverer boxer, and did not quite know where to look for the next one in the concluding minute.

Birth.

COPLANS.—On July 29th, 1920, at Cape Town, to the wife of S. H. Coplans, L.D.S., a daughter.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE futility of the present-day "certificate of the cause of death" has long been realised by the medical profession. The recent *cause célèbre* has, however, brought its faults to the knowledge of the lay public, and we are not surprised to find urged in the press many suggested improvements, more or less useful.

The French plan of demanding two medical signatories, the second being the *médecin certificateur* of the area, empowered to question the patient's friends and relations, and thus to obtain a general history of the case, has many supporters. Such an institution, while presenting some difficulties, would relieve the family physician of the responsibility of deciding to withhold a death certificate on account of some minor circumstance unexplained by the clinical history of the case. It would also facilitate the pathological investigation of "interesting cases," since few doctors are able to risk financial loss by insisting on post-mortem examinations on their own responsibility.

In areas where the coroner is an experienced medical man, the difficulties might well be met by enabling him to carry out preliminary investigations and to order a post-mortem without necessarily involving an inquest. In less favoured areas the solution of the problem would appear to lie in either appointing a medical man as coroner, or, in the infinitely harder task of educating the lay profession to regard pathological investigation of the dead, not as a desecration, but as a work in the interests of future generations.

ANOTHER medical topic in which our lay contemporaries have recently developed a vicarious interest is that of blood transfusion. We forget the exact circulation of the paper concerned, but many folk have probably followed with interest the search for the required donor, and have shared our regret at the somewhat prosaic ending—the selection of the student clerking to the case. While appreciating her action, we should be glad to see a regulation that no student or nurse in the wards should be *allowed* to act as donor, except, of course, in a case of real urgency. In spite of the example of some of our own students, we feel that if once the precedent is firmly established it will be a distinctly dangerous one. Apart from the lowered resistance of the donor, and the consequent increase of the risks he runs in his daily contact with infectious disease, a medical man can only merit the trust of his patients if he keeps himself at the highest

level of bodily fitness possible in his circumstances, and thus is prepared for emergencies which may arise.

Usually at this Hospital it has been found possible to arrange for some other member of the patient's family to provide the transfusion fluid. Such an arrangement not only clears up the financial side of the question—and we have recollections of a sordid strike of donors in New York some months back—but may very likely in the future be found to be more to the interest of the patient, since it is unlikely that our four blood groups of the present day exhaust the familial differences between the red cells of different individuals.

PROBABLY every number of the GAZETTE that has appeared in early December has had some remark on the propinquity of Christmas as judged by the sounds issuing from the Residents' Room in the evenings. This year's selection of songs seems as varied as ever, and the practice of the performers as vigorous. We have no doubt that when Christmas arrives, their songs, with the charm of novelty that they have lost long since for those within earshot of the "Nigger" practices will once again be voted the best on record.

IT has fallen to the Boat Club, the youngest of the constituent institutions of the Clubs' Union, to hold the first Hospital social function this winter. As announced in our last issue, a Dance will be held on Thursday, December 9th, at the Wharncliffe Rooms.

The Committee has wisely kept the price of tickets sufficiently low for the average student's purse, and, therefore, rely for success on the support of all Guy's men, both senior and junior, who can thus, while enjoying themselves, ensure a good start when the Club rowing season opens next spring.

NOVEMBER 16th saw the passing of the last generation of Residents, and the arrival of the new one. We welcome Messrs. Campion, Coburn, Gibb, Gill-Carey, Lindsay, and Massie to the dignified positions they now occupy, and congratulate Mr. Glover on his election as President.

CHRISTMAS CARDS with views of the Hospital (with envelopes) can be obtained from Miss Smith at the Matron's Office, or from the Wills Librarian. The proceeds from the sale of these cards, which are presented by Messrs. Ash & Co., will, as in previous years, be devoted to the Hospital. Price 3d. each; or 5 for 1s.

M. H. M.

Interesting Cases in the Medical Wards

CLINICAL.

Stephen	28	Neurological.
,,	29	Myxœdema.
,,	33	Neoplasm.
,,	41	Heart disease.
,,	40	Neurological.
Esther	22	Tubercular peritonitis.
,,	24	Hypopituitarism.
,,	26	Compression paraplegia.

Dr. Hurst and Dr. Hunt—

Addison	8	Aortic disease.
,,	10	Addison's disease.
Mary	35	Functional paralysis.
,,	34	Disseminated sclerosis.
,,	21	Rheumatoid arthritis.

Dr. Beddard and Dr. Mutch—

Esther	1	N.Y.D. Ascites. Obstruction, inferior vena cava.
,, Cot	B	Fibroid lung.
,,	6	Bronchiectasis.
Stephen	17	N.Y.D. Ascites.

Change of Address.

Frank Cook, F.R.C.S., to 10, Vincent Square Mansions, Westminster, S.W.1. (Telephone Victoria 7538).

T. L. Heath from Poplar & Stepney Sick Asylum to St. Andrew's Hospital, Devons Road, Bow, E.3., on change of title of the Institution.

The Misses Mutford and Sharwood, St. Margarets Nursing Home, Sidmouth, Devon.

F. Bocquet Bull, 58, Wimpole Street, W.1. (Phone Mayfair 1086).

Douglas H. N. Galbraith, M.C., M.R.C.S., L.R.C.P., The Walk, Launceston, Cornwall.

Leopold Mandel, M.D., M.R.C.P., 40, Harley Street, W.1.

Dr. C. P. Symonds, 58, Portland Place, W.1.

Hour-Glass Contraction of the Stomach.

CLINICAL LECTURE BY R. P. ROWLANDS, M.S., F.R.C.S.

GENTLEMEN,—I have brought no patients to this lecture, for there is little to show after operation for hour-glass contraction. Photographs, diagrams and X-ray pictures shown on the epidiascope are more instructive. I propose to give you a detailed account of one of my first cases because it was unusually interesting, the lady only weighing four stone before operation, and now she weighs over 10 stone. I shall give very brief accounts of two recent cases.

CASE 1.

Mrs. M.D., an American lady, aged 42, was brought to me by Dr. J. C. Cook towards the end of October, 1909.

History.—She gave a history of lifelong constipation and indigestion. About ten years ago she began to have attacks of biliary colic about once or twice a year, but these entirely ceased four years ago. She has never been jaundiced. Since she was a girl she has suffered a great deal from indigestion. For the last three years she has had almost constantly a dull pain in the epigastrium, but this has become a great deal worse within the last few months, and has lately shifted up the sternum as high as the sternal notch, where it is sometimes very severe, especially when the patient swallows. The indigestion has been very bad during the last eighteen months. At first she used to vomit about once or twice a week, but gradually this has increased in frequency to once every day, and lately after every meal containing any solid. She has never had hæmatemesis or noticed melæna. Gradually the amount that she can swallow at a time has diminished. After the food she has the feeling of a lump in the throat and under the breast-bone. For months she has not been able to take solid food in comfort. The attempt has always been followed by great pain, which is only relieved by the return of all the food. One day she took an oyster divided into four pieces; this was followed by great pain and vomiting, which was only relieved when the last piece of oyster was returned four hours later. The only solid that she could occasionally take in comfort was a Welsh rarebit. Occasionally her mouth fills with water, and then she brings up a small amount of mucus. The act of swallowing itself is not painful if the patient is content with a small amount of liquid at a meal. For the last year she has not been able to take tea. For months she has lived on peptonised milk, Benger's food, Brand's essence, and so on, in decreasing quantities at a time. These have been supplemented by nutrient enemata and suppositories. She was wasted progressively for two years, but much more rapidly during the last six months. About two years ago her weight was 130lb.; now she is only 56lb., although she is 5ft. 9in. in height. During the last few months she has had several attacks of shivering, associated with exacerbation of vomiting. In spite of all this the patient has led an active life, often travelling 200 miles a day in her motor car, and managing the business affairs of her daughter. She was taken to see a well-known consulting physician in May, 1909, who is said to have diagnosed malignant disease in the abdomen, possibly in the stomach or pancreas. He gave a bad prognosis, and advised that the patient should be allowed to live and do as she liked.

Fig. 1.—Case 1: A month before operation. She was thinner at the operation. She weighed 56lb.

Condition upon examination.—The patient was extremely thin and feeble (Fig. 1). She was only able to walk into my consulting room

with difficulty. She was not able to dress or undress herself. Her skin was yellow, dry, and wrinkled. The temperature was 97°. The hands and feet were cold. There was some œdema of the ankles.

Alimentary System.—All the natural teeth were missing, having been extracted about fifteen years ago and replaced by complete sets of artificial teeth. The tongue was raw and red. When asked to swallow a glass of milk she was only able to take half a tumblerful in small sips. Any attempt to take more gave rise to pain and a feeling of distension at the lower end of the sternum. The abdomen was carinated, and in spite of the fact that the abdominal wall was very high, no tumour could be felt anywhere in the abdomen. There was a little resistance in the gall-bladder region, but no dullness or tumour. A succussion splash could be obtained a little below the level of the umbilicus. A pelvic examination revealed no abnormality. The respiratory system was normal, in spite of a history of possible phthisis at the lower part of the right upper lobe. The nervous system was normal except for great irritability of temper. In view of the difficulty of diagnosis between œsophageal stricture and hour-glass contraction of the stomach with pyloric obstruction, an X-ray and bismuth examination of the stomach was advised. Three days later the patient was asked to swallow a tumberful of milk containing 1 oz. of the oxychloride of bismuth. After much coaxing she was only able to swallow half this amount. She was then placed standing before the X-ray apparatus. It was at once seen that the œsophagus was not distended, so that the obstruction could not be in it. A small shadow was seen just below the diaphragm, and from the right border of this a narrow streak of bismuth extended into a lower shadow, giving the characteristic appearance of hour-glass stomach, with an unusually small cardiac pouch (Fig. 2). As the patient swallowed more bismuth the lower shadow gradually increased until it was much larger than the upper one. It extended from two inches below the umbilicus to a little below the symphysis pubis. The fluid took a long time to run away from the upper sac, so that the obstruction was evidently severe. The size of the pyloric pouch and the delay in the exit from the stomach made it clear that there must be pyloric obstruction as well. An operation was advised, and the patient consented. The next day was spent in preparation. The patient was given nothing but sterilised milk and boiled water by the mouth and nutrient enemata and salines were also administered alternately every four hours. This improved the pulse and the general condition of the patient to a great extent. The false teeth were taken away and the mouth thoroughly cleansed several times a day with an antiseptic mouth wash.

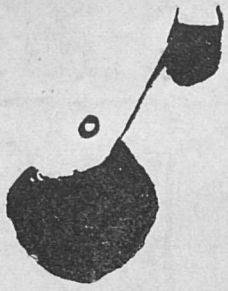

Fig. 2.—Case 1: Hour-glass contraction and pyloric stenosis. Bismuth shadows. Note unusually small size and high position of the cardiac shadow above and to the left of the umbilicus o. The pyloric shadow was partly behind the pubis, and took some time, and repeated swallowing of small amounts, to reach the size indicated.

Operation.—On the morning of the second day after the examination Dr. Page gave an anæsthetic, and the abdomen was opened through an incision made as high as possible in the left rectus muscle, some of the fibres of which were cut across in order to give more room. The stomach was explored, and the conditions suggested by the X-rays were discovered. The upper pouch was very small, being about the size of an ordinary hen's egg. The lower pouch was fairly large, being about the size of a normal stomach. The pylorus was considerably narrowed, but fairly movable. The scar of a healed ulcer was seen upon its anterior surface. The constriction in the stomach was very hard and tight. There was not enough thickening of the wall to suggest carcinoma, nor were there any signs of any enlarged glands in the small or large omentum or pancreas. The stricture was 3 inches long and appeared to be due to the healing of a large saddle-shaped ulcer occupying the lesser curvature quite close to the œsophagus and extending far downwards upon both the anterior and posterior walls of the stomach. The lower part of the stomach was pulled down-

wards and to the right so as to bring the cardiac pouch into view. For reasons that will be presently discussed, a gastro-gastrostomy was decided upon. It was found to be impossible to control the cardiac pouch with clamps without passing one blade through the gastro-colic omentum into the lesser sac of the peritoneum and upwards behind the stomach towards the œsophagus. The other blade was placed in front of the stomach and the lesser omentum, and the forceps were locked and closed. Another long clamp was applied on the anterior wall of the pyloric pouch near the greater curvature, and with its points directed upwards and to the left. The clamped portions of the stomach were then carefully isolated with moist packs, and they were joined together by two layers of direct sutures, just as in gastro-jejunostomy. Linen thread was the suture material used. The opening in the cardiac pouch extended from the lower and right border upwards, and to the left of and above the œsophageal orifice (Fig. 3). This was the only way to make it long enough. The wall was extremely thick and hard. The mucous membrane was inflamed and closely adherent to the other coats, so that none of it could be removed separately. Therefore an ellipse of the whole thickness of the fibrous wall was removed. It was impossible for the through-and-through suture to pick up the mucous membrane all the way round without unduly narrowing the anastomotic opening; but the other coats were so extremely fibroid that there did not appear to be any danger of the stitches cutting out. The external sero-muscular suture having been completed, tags of the lesser and gastro-colic omenta were fixed over the suture line. The pylorus was then brought into the wound, and an incision was made along its supple lower border and prolonged into the lower borders of the duodenum and stomach, which were close together. The wound was closed after Finney's method of gastro-duodenostomy, but with continued instead of interrupted sutures. Before the opening was made, clamps were applied to prevent leakage and hæmorrhage. The gall bladder was found to be full of stones, but it was neither inflamed nor adherent, and the cystic duct was patent. There was no indication for removing the stones, especially as any prolongation of the operation would probably have resulted fatally. Moreover, the gall stones had given rise to no symptoms for five years. When the operation was completed the stomach seemed to be about the normal size and shape. The new pylorus was very wide. The gastro-gastrostomy had drawn the pyloric pouch upwards and to the left. The abdomen was closed in layers, the operation being completed in forty-five minutes. A saline enema was given immediately on the return of the patient to bed. The patient was rather collapsed for the first two days. She was given water to drink from the first, and saline and nutrient enemata were administered alternately every four hours. The mouth was exceedingly dry and thirst was very severe.

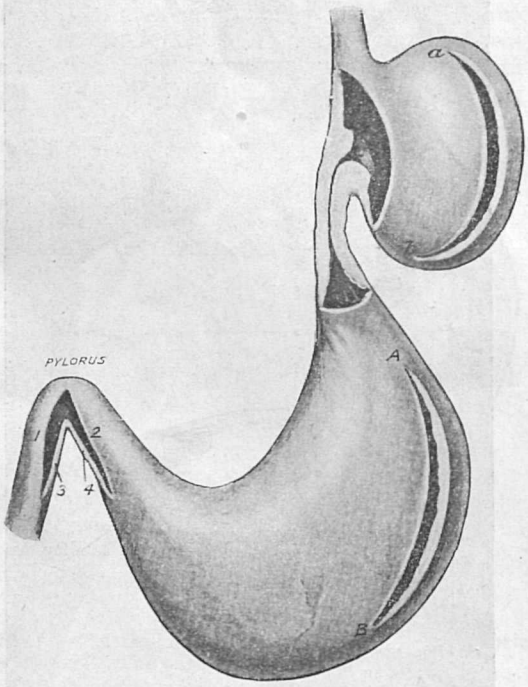

Fig. 3.—Case 1: The cardiac and pyloric pouches were anastomosed, A, *a* and B, *b* being joined together respectively. The constricted pylorus *p* was greatly enlarged, after Finney's method. The incision along its lower border is shown extending into the duodenum and stomach. The edges were sewn together in such a way as to enlarge the pylorus without tension 1 to 2 and 3 to 4.

Towards the end of the second day milk was given by the mouth, and from that time onwards nutrients were discontinued. The food given by the mouth was gradually increased so that at the end of fifteen days she was on minced full diet. Gradually she became able to swallow larger amounts at a time. She left

the home after five weeks with her condition very much improved, having gained over a stone in weight (see Fig. 4).

By September, 1910, she had gained 3 st. 10 lb. In 1912 she weighed 9 st., having more than doubled her weight I removed gall stones impacted in the common bile duct and cystic ducts in February, 1913, and the patient made a rapid recovery. She has remained in

Fig. 4.—Case 1.

perfect health up to the present time (November, 1920), and looks younger than she did 11 years ago.

CASE 2 (sent by Dr. Hurst).

Hour-glass Contraction with Pyloric Obstruction.—Miss E. M., admitted to hospital December, 1919, after suffering for many years from gastric symptoms culminating in obstruction. At the operation an hour-glass contraction was found with the pouches about equal in size. The contraction was not very narrow and the ulcer was slung up by a band of adhesions to the anterior abdominal wall. There was also pyloric obstruction due to a contracted duodenal ulcer. There were no gall stones.

I first performed gastro-jejunostomy and then gastro-gastrostomy. The two operations lasted 50 minutes. The patient put on much weight and was very well when last seen in October, 1920.

CASE 3 (sent by Dr. Hurst).

Mrs. S., aged 58, came to see me in Novemday, 1919.

History.—Patient had had frequent attacks of indigestion since she was about 20, and went under treatment for this soon after the birth of her first child 27 years ago, when she brought up two considerable quantities of blood and also passed some by the bowels. She had a similar attack two or three years later, and since then has suffered pain and vomiting after taking food, this becoming worse and more frequent. The pain was relieved by vomiting. Vomit often contained food taken more than 24 hours previously.

When I saw patient she was living largely on bread and butter and milk. She was very thin. X-rayed by Dr. Hurst, who diagnosed hour-glass stomach. I operated on her and performed gastro-gastrostomy. Patient made good progress after operation. X-ray examination a month later showed the stomach to be normal in shape. In November, 1920, she was very well.

REMARKS.

Etiology and Pathology.—Although at one time hour-glass contraction of the stomach was thought to be congenital, it is now known to be nearly always due to the contraction of a chronic ulcer, usually situated on the lesser curvature of the stomach. It has been found in 6 per cent. of the cases of gastric ulcer at the Mayo Clinic.* This ulcer is deep, involving the walls of the stomach, and usually has become adherent to the liver, pancreas, or anterior abdominal wall. Very gradually the walls of the stomach become indurated and the greater curvature is also drawn up by perigastric ad-

*Eusterman Mayo Clinic, 1914, page 20.

hesions, and a real stricture results. Practically always the ulceration persists at the upper opening of the stricture, and there is usually a considerable degree of spasm of the stomach which increases the obstruction. Occasionally the stomach is trifid, due to the contraction of two ulcers. In some cases carcinoma supervenes upon the gastric ulcer and causes or exaggerates the hour-glass contraction. Eusterman reports three cases of luetic hour-glass contraction with multiple ulcers.

In one case a congenital gastric fistula led to contraction at the site of the fistula, and in a specimen in the Guy's Museum the hour-glass contraction is due to gastrostomy. Sandifort found an hour-glass contraction in a new born child; it was uncertain whether this was congenital or due to a fœtal gastric ulcer.

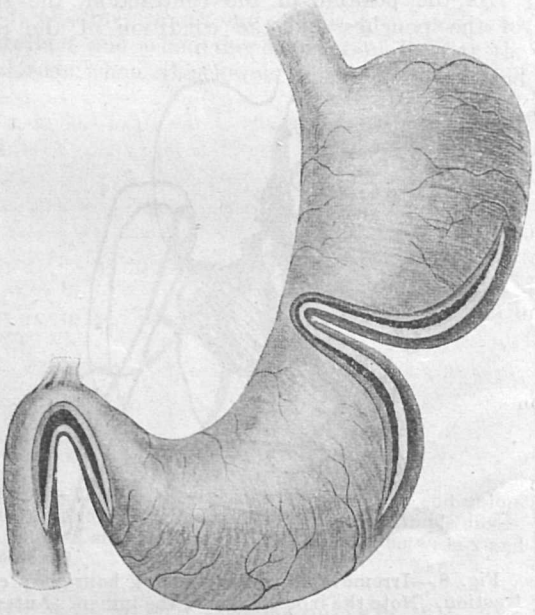

Fig. 5.—Gastro-plasty (Kammerer). Gastro-duodenostomy (Finney),

I have operated on three cases of false hour-glass contraction due to bands round the stomach slinging up the greater curvature. In one of these a broad sling had resulted from perforation of a gastric ulcer; in another, the obstruction was due to a sling of adhesions around the stomach arising in a cretaceous gland a little below the œsophagus; and in the third I could find no cause for a thin strong band running across the stomach from the lesser omentum, above the middle of the lesser curvature, to the great omentum just below the stomach, obviously constricting it and hitching up the greater curvature.

Signs and symptoms.—These are generally those of chronic gastric ulcer with gradually developing obstruction, and have lasted for many years, anything from one to 30 or even more. Three-quarters of the patients are women.

The chronic course of the disease is dependent upon the position of the ulcer opposite a wide part of the stomach where it takes a long time to cause obstruction. It is notable that in my only case in which the ulcer was in the pre-pyloric region the symptoms progressed far more rapidly, and terminated in tetany within two years of the first symptoms.

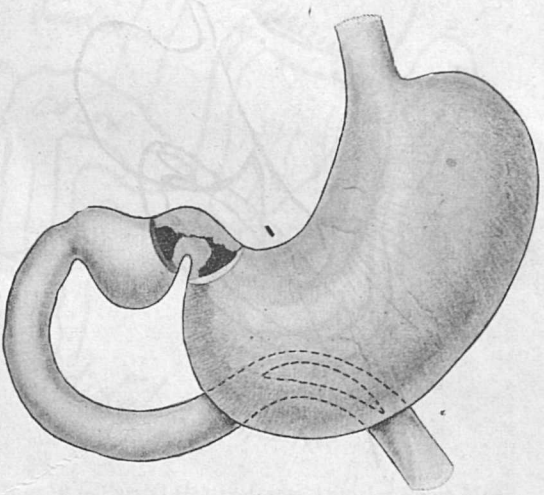

Fig. 6.—Gastro-jejunostomy. There was no pyloric obstruction. The patient had gastric tetany.

Nearly all the patients are unusually thin and ill so that in many cases malignant disease is strongly suspected. When the contraction is near the cardiac orifice and the upper pouch is very small, such symptoms as dysphagia and ability to take only very small feeds have suggested cardio-spasm or organic stricture of the œsophagus. Severe pain and tenderness in the left epigastric angle are noted in nearly every case. The pain usually comes on within two hours after a meal, and is relieved by vomiting or by alkalies. Hyperchlorhydria is usually present, but in a few late cases the acidity may be normal or subnormal. Then carcinoma is generally diag-

nosed. In a third of the cases there is hæmatemesis. In exceptional cases there is a palpable swelling in the epigastrium.

Diagnosis.—Most of the complicated methods of diagnosis in use some years ago are now of historical interest only, for radiography has replaced them and is far more reliable. One of them, however, must be mentioned, namely, the escape of turbid or foul fluid or food from the tube when the stomach has apparently been washed clean.

Even radiography has certain fallacies and requires some judgment and experience to check it. A dilated atonic stomach, examined in the vertical position, may show an hour-glass shadow, but Dr. Hurst pointed out that the opaque meal reaches the pyloric segment

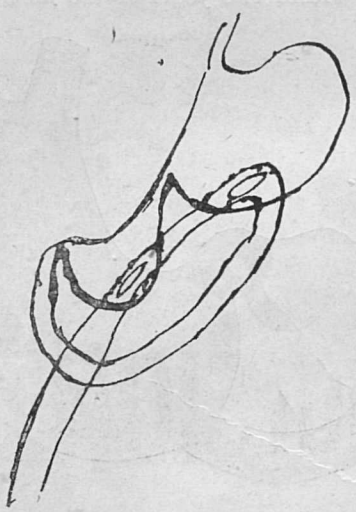

Fig. 7.—Double post gastro-jejunostomy not recommended.

immediately after swallowing, instead of gradually, as in true hour-glass contraction, and the hour-glass appearance also vanishes as soon as the patient assumes the horizontal position.

The position and shape of the narrowing is also quite different in the two conditions. In practically all cases of true hour-glass contraction, the food passes from the right border of the upper pouch instead of from its lower end.

Other fallacies arise from spasm of the stomach causing an incisura, or deep notch on the greater curvature, opposite an ulcer. A similar reflex spasm may be due to any disease in associated organs, such as the appendix, gall bladder, pancreas, or intestine. In one instance, repeated radiograms of a man's stomach showed hour-glass contraction, but none was found at the operation, but an appendix full of pus was removed from the pelvis, adherent to the bladder, and its removal permanently relieved all the gastric symptoms. This spasm may be seen to pass on watching or palpating the stomach, especially after giving belladonna.

Treatment.—Although medical treatment can relieve the symptoms considerably it is clear that the only hope of cure is by an operation, and it is fortunate that the results of surgical treatment are very good.

As the position of the contraction, the size of the pouches and the condition of the py-

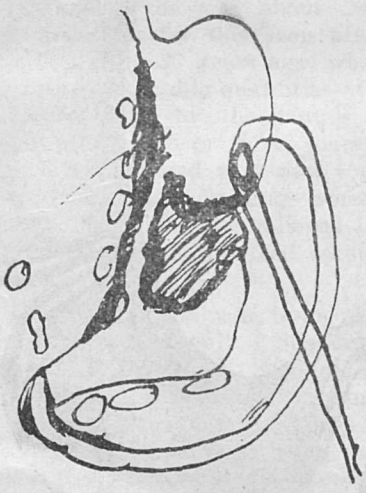

Fig. 8.—Irremovable cancer causing hour-glass contraction. Note the irregularity of the lumen. Anterior gastro-jejunostomy was the only operation possible. It gave relief for six months.

lorus differ greatly, it is obvious that different operations have to be adopted to suit the different circumstances.

1. *Gastro-gastrostomy* (vide Fig. 3).—As a rule this is the most satisfactory operation, for, when well done, it effectively and permanently removes the obstruction without altering the physiological condition of the stomach, and without trespassing on the ulcerated stricture, through which the food need pass no more. Moreover, it is a very safe operation and carries no risk of vicious vomiting or gastro-jejunal ulcer, which still occasionally follow gastro-jejunostomy. When the upper pouch is very

small gastro-gastrostomy may be difficult, but by making a curved incision (as shown in Fig. 3), a sufficiently large opening can be obtained. This operation is much more easily done on the front of the stomach, for adhesions in the lesser sac and distortions of the stomach make a posterior operation very difficult without any compensating advantage.

2. *Gastro-plasty* (Kammerer).—This is not nearly such a satisfactory operation, for by it the stricture and the ulcer, which is practically always present, are laid open and the prevention of bleeding and the sewing are more difficult, owing to the adhesions which generally bind down the contracted part of the stomach. (Fig. 5).

3. *Gastro-jejunostomy*.—This operation is an excellent one when the contraction is near the pylorus, when the lower pouch is small and

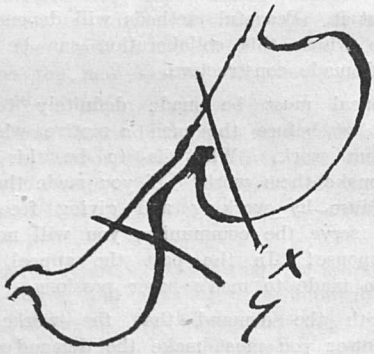

Fig. 9.—Cylindrical resection with end to end union. Difficult and severe and too dangerous for simple ulcers. Not radical enough for carcinoma, Part between x and y removed.

there is no pyloric obstruction (Fig. 6). The case, then, hardly differs from the usual pyloric obstruction, but for ordinary cases the operation is not so suitable, because the opening in the upper pouch of the stomach has to be so high and far to the left that the best and highest part of the jejunum cannot be satisfactorily engaged, with the result that the operation carries an unusual risk of vicious vomiting. I have had to do a secondary entero-anastomosis in such a case.

When there is pyloric obstruction as well, and the two pouches have to be drained, a double posterior gastro-jejunostomy has been suggested (Fig. 7), but this is very difficult to perform satisfactorily through the small space available without risk of kinking and vomiting. Posterior gastro-jejunostomy engaging the lower pouch, with gastro-gastrostomy joining the two pouches, is far better under these circumstances, but when the stenosed pylorus is freely movable and can be delivered, gastro-duodenostomy (Finney's operation) is better still because it can be done more easily, in less time and without incurring any of the special risks of gastro-jejunostomy.

Occasionally an anterior gastro-jejunostomy is the best means of relieving high hour-glass contraction with a small upper pouch, especialyy when the condition is due to irremovable

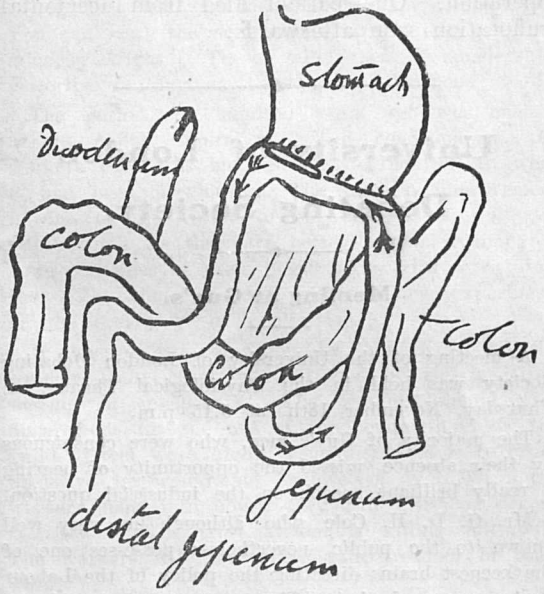

Fig. 10.—Partial Gastrectomy, Anterior Polya-Mayo.

Copy of Diagram by C. H. Mayo, ANNALS OF SURGERY, *Aug. 1919, p.* 238.

malignant disease (Fig. 8). In one case of this kind it prolonged and made life comfortable for six months.

4. *Sleeve Resection*.—Sleeve resection of the part of the stomach bearing the stricture has been very strongly recommended by some surgeons, but it is usually unnecessarily severe for simple ulcers and it exposes the patient to undue risk (Fig. 9). For malignant disease it is not extensive enough to be radical.

5. When cancer is present or feared, the more extensive classical operation of *Partial gastrectomy, after the Polya-Mayo method, is much better* (Fig. 10).

6. Retrograde dilatation of a very high stricture is sometimes the only possible operation and it has proved successful, especially when followed by the diligent use of an œsophageal bougie.

Mortality.—Veyrassat's Statistics (Rev. de Chir., 1908) give a mortality of 26, *i.e.*, over 16 per cent., for 260 operations, but some of these were due to draining the pyloric instead of the cardiac pouch. More recently the results are much better. I have operated on over 20 cases, including three for malignant disease, and have had no deaths due to the operation. One patient died from accidental suffocation soon afterwards.

University of London Debating Society.

Meeting at Guy's.

A meeting of the University of London Debating Society was held in the Physiological Theatre on Thursday, November 18th, at 5.15 p.m.

The majority of Guy's men, who were conspicuous by their absence, missed the opportunity of hearing a really brilliant speech on the industrial question.

Mr. G. D. H. Cole, who, although not very well known to the public, nevertheless possesses one of the keenest brains directing the policy of the Labour Party, proposed that "The present malady of the Capitalist system can be cured only by the assumption of power in industry and politics by the organised workers."

The Capitalist system, he pointed out, has failed for diverse reasons. The stability of international commerce no longer exists. The attitude of the workers towards the social order has undergone a great change. They no longer acquiesce in their position in the Capitalist system. There is a growing unrest and distrust of Capitalism. There is an increasing liability of strikes. It is thus more difficult to secure continuity of production, rendering extremely difficult the continued functioning of Capitalism. There is also a steady relaxation of effort, arising because of the distrust of the Capitalist order. This relaxation applies also to the managerial part of industry, which all leads to less good work being performed. This is hindering the capitalist system from supplying the necessities of life. In view of the fact that these conditions arise from the withdrawal of belief in Capitalism, this system cannot be restored. A new industrial and social order is necessary.

You cannot restore health to industry unless you have on the side of health the great force that has demonstrated the inefficiency of the present system. If you have the withdrawal of the actual producers you must have a new system.

Turn the force of Labour from a critical into a constructive force. Put the responsibility on to the organised workers.

Organised workers must not mean only the manual workers. In Labour the movement to-day is the alliance of the manual and brain workers. It is by the collaboration of these two classes of workers that the new social order will come into being. The tendency of middle class workers to go over to Labour will increase in the future. This combined force will be so strong that nothing in the Capitalist system will be strong enough to stand up against it. Peaceful methods will depend on the extent to which this collaboration can be brought about and made constructive.

An appeal must be made definitely to a new motive. Set before the men a motive which will make them work. What is to be this inducement to make them work? If you made the appeal that, because by working and giving free service they will serve the community, you will not get a small response! In the past the appeal has always been made to men's baser passions.

But with the demand that the workers shall assume power you must make the demand that the workers shall assume responsibility. You must conceive of this transformation in terms of power. It will be built in the growing self-confidence of the mass of workers that they can not only overthrow but replace the present system.

Mr. Cook Taylor, Hon. Sec. of the University of London Liberal Association, opposed the motion.

The national debt, he declared, will remain under all conditions. Compare the condition of the working man to-day to what it was a hundred years ago. In the last hundred years education has proceeded at any extraordinary rate. This has come about owing to Capitalism.

Previous efforts at Guild Socialism have failed owing to absolute incompetence. In the Guild System all industries would be organised in guilds with the result that individual factories could not carry out experiments in organisation. Why do not the workers try their system now, e.g., by buying a coal mine and working it themselves. If the new system gives better goods, etc., then every right thinking man will support it. The workers in these experiments have failed because they will not elect

good managers, and they are adverse to new methods because they will, some of them, be thrown out of work. The people are already apathetic to general elections; they will therefore be no less apathetic to the management of their own industry, which will fall into the hands of officials.

Mr. Weinbern maintained that "ca' canny" would still be existent under the new system. He had himself, in the case of miners in South Africa, tried appealing to the highest motive of all, the safety of the miners' own lives, and this had in many cases failed.

Miss Bowler, replying to the Hon. Opposer, stated that it is education which has enabled people to see the fallacies of Capitalism.

Mr. Garratt (V.C.) asked the House to consider the confusion of the present day, the slums, etc., and to look at the "triumph" of Capitalism.

There is a great necessity for the amalgamation of the middle with the working classes. It is up to everyone to throw in their lot in this effort to raise the level of the social system. One cannot guarantee the new system till the experiment has been tried.

Mr. Olver maintained that the Capitalist is a necessity. Cannot the Capitalists and the Workers pool their resources for the good of the country? The workers, if they desire power, should assume it at the polls.

Mr. Lyton (Bart.'s) stated that the workers should assume power, but that this is impossible at the polls. People are as sheep and are led by the Capitalist press (e.g., *Daily Mail*).

Mr. Kirkland stated that an appeal to higher motives is impossible. It was Capitalism that raised France when it became bankrupt after the Revolution.

Miss Dixon (Bedford) maintained that people will work if money is not the aim. Under the communist system everyone will work, and there will be no idlers living on others' work.

Mr. Pigott thought that the hon. proposer desired to put a new Capitalism in the place of the old.

Mr. Guest supported the attack on the opposition. Everything at present points to the decadence of Capitalism. There is no progress but retrogression. Socialism may fail, but Capitalism is definitely failing.

Before the summing up the President proposed a vote of thanks to Mr. Cole. This was heartily received.

Mr. Cook Taylor, in his reply, laid stress on the point that if one took the evils of Capitalism to be due to Capitalism one must also take the achievements of Capitalism to be due to Capitalism.

Mr. Cole, on rising, thanked the Society for his reception. The discussion had reminded him of the occasion on which he received a letter stating that Lord Northcliffe requested him to write an article for the *Daily Mail*. The following article "How I would run the *Daily Mail* under Guild Socialism," by G. D. H. Cole. "There are no snakes in Iceland," was returned, but has never appeared in the *Daily Mail* from that day to this.

One must take the chance that the workers will work under the new system. They will certainly not work under Capitalism. If the new motive will not make men work then civilisation is going to pieces.

You must deal with men's instinct for co-operation. You can start the new system if you can get your minority right. These will then persuade the majority working on their group instincts.

The period one hundred years ago was one of misery under Capitalism. The condition of the workers then was an absolute degradation to what it had been previously. The modern improvement is due to the revolt of the workers in spite of Capitalism. As they are better organised they are more conscious of their power to overthrow Capitalism. The choice is now either a new experiment or the overthrow of civilisation.

In answer to a question by Mr. Kirkland, the speaker stated that he did not believe in profit sharing or in profits. The workers should produce goods for the use of the community. If the guild system were highly centralised so as to crush initiative he would not believe in it. When the workers come into power they will insist on decentralisation. The trust system is killing initiative. The workers will try and obtain freedom in their work.

Wherever possible the guild system is being put into force. In the mining industry land possessing coal beneath the surface has been purchased. In starting this competition against Capitalism, however, Labour finds itself up against a boycott. For instance, the Capitalist organisations which control the cement supplies in England would not supply the recently founded Building Guild with cement till after they started importing it from abroad. It is significant also that private contractors offering higher wages for luxury building cannot withdraw labour from the Building Guilds.

Medical men do not work with money as their object. If this spirit is shown in medicine it can be created in industry.

You must make the right appeal to those people who are capable of performing a useful service to the community.

The House then divided on the motion, which was carried.

A Case of Hepatitis and Myocarditis with Anasarca and Ascites.

History of J. B., æt. 60. A very abstemious, hard-working tinsmith, owner and employer of a nice business. Never ailed much until November, 1918, when he was run down in health owing to his two sons (employed in the business) going out to the Great War. He then (November, 1918) had an attack of influenza with bronchitis, would not lie up long enough, went out too soon, then he had myo-carditis in March, 1919. Some anasarca of hands, face and legs followed; after that a huge liver, with very large nodules upon it. He had auricular fibrillation and irregular beats, in rate and strength, with mitral stenosis and some aortic mischief—pulse 120. Tachycardia, pallor of skin, but occasionally much cyanosis, semi-consciousness, twitchings. Shortly after I called in a physician, who prescribed Caffeine, Tr. Nucis Vomicæ, Tr. Digitalis, and Sodium Sal. Theobrom., Potass Acetas, or Strophanthus in a wineglassful of Decoct. Scoparius every 4 hours. After finishing off a Winchester of this, and as he was getting no better, I had recourse to oxygen inhalation for the increased cyanosis (blue at his toes and fingers); then I expressed the opinion he would die, but after an extremely liberal recourse to oxygen, continued for many weeks, he picked up a bit. My treatment was Tr. Digitalis m.xx., Potass Bicarb., Caffeine and Spt. Am. Arom.; also gave Pulv. Jalapæ Co. 1 oz. three times a week —also Mist. Alba.

Things began to hum a bit, gradually at first; the heart and liver improved, cyanosis diminished, and about February, 1920, the liver became normal, heart much better, and the anasarca left the legs and scrotum and face, but there was evidently some ascites, about one pint, which would not go. Then I thought, why not try Calomel with the Jalapæ Co.? I did so, two or three times a week, and although ascites and anasarca returned about July it all disappeared, the liver again became normal, the cyanosis left, fibrillation, &c., disappeared, &c.,

Carefully we got him up, and at the end of September, 1920, he got out in a bathchair. As he could not sleep and was much pained about the liver (? contraction), I gave him Liq. Morphia with Tr. Digitalis a.a. ½ oz. in strong Aqua Chlorof., which he still takes p. r. n. at night. This was increased to 1 oz. of each with great benefit. Even now he still takes the mixture when required, say twice a week, and nothing else.

REMARKS.

The inadequacy of Decoct. Scoparius. Of course, the Theo-bromate of Soda Sal. was only given for two or three days at a time, with absolutely no effect.

Paracentesis I did not have recourse to, for he would have snuffed out with cardiac failure. I let out the fluid in several places in both legs and thighs with benefit.

The continued and frequent inhalations tided over the cyanosis. Many, many gallons were inhaled, but with marked success.

In my opinion the liberal use of Calomel and Jal. Co. cleared off the ascites—together with Sodium Sulphate.

Personally I never saw a case of ascites clear up before, with or without paracentesis and Tobin's tubes. No doubt the large doses of Digitalis assisted the ascites and the heart.

At first the patient showed signs of pulmonary congestion (? hypostasis), but luckily disappeared. It is well to be heroic when you understand the patient!! Anyhow, it is very pleasant to obtain the gratitude of the patient and his friends, and more especially to have the patient recover, which to me is *the* essential desideratum. We who love our profession consider payment a very secondary consideration, but one not to be unappreciated. "Play the Game." Our profession ought to be above sordid considerations. I trust I learnt the good old Guy's motto "Dare quam accipere." At all events, I always try to act up to it.

In conclusion, I really thought this case might be of some future assistance to a poor wearied doctor who has at some future time to tackle a similar case. Sir Samuel Wilks taught me to be heroic (when necessary) with Digitalis.

My patient will have to take Digitalis all his life. I shall put him on Pil. Digitalis, Nux Vomica, &c.

I owe the Editor of the GUY'S HOSPITAL GAZETTE an apology for this long-drawn account.

W. H. SPURGIN.

Newcastle-on-Tyne.
October 30th, 1920.

Disposal of Old Books.

The Wills Library Committee have decided to dispose of various old books belonging to the Library, and Guy's men requiring any of these works should make application to the Wills Librarian who has instructions to present them on behalf of the Library Committee.

Attention is also called to the notice in the last issue of the GAZETTE re the sale of books and instruments.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The War Memorial.

DEAR SIR,—In a recent issue, when describing the nature of the visible memorial which it has been decided to build at the College entrance to the Hospital, you set out the words which it was proposed to engrave thereon. At the same time you stated that these words were only provisionally agreed upon and asked your readers to suggest alternatives. The selection of appropriate words on such a memorial is always difficult, but this makes it all the more necessary that pains should be taken to choose them. I much hope that your readers will send you suggestions, for the words you print seem to halt a little. There is something to be said in favour of a Latin inscription, and perhaps Sir Cooper Perry might be asked to add another to his many services to Guy's by submitting appropriate classical sentences. The proposal as I understand it is that on the outside of the archway looking into Maze Pond a statement of the object of the memorial should be made, and that inside on the Hospital face of the archway the 110 names should be inscribed, apparently on the columns supporting the archway. This will perhaps be clearer when we see the drawing of the memorial you promise us in an early issue of the GAZETTE.

If it is decided to have the inscription in English I venture to suggest the following:—

Outside—"In memory of the 110 Guy's men who gave their lives in the Great War, 1914-1918."

Inside—"Died for their Country, 1914-1918."

I am, yours faithfully,

SUBSCRIBER.

November 15th, 1920.

A Case of Triple Intussusception of the Jejunum.

Gladys F., æt. 17 months, was admitted into Lydia ward under Mr. Steward in the late afternoon of October 7th, 1920. The previous evening she went to bed apparently perfectly well, but during the night her mother noticed that she was rather restless. At 7 a.m. on October 7th she passed a blood-stained motion, followed at 8.30 a.m. by one containing "slime" in addition. She was brought to the Front Surgery at 10 a.m., but no physical signs being detected and temperature and pulse being normal, she was sent home. The mother was instructed to bring the child up later if symptoms persisted, and also to bring a specimen of the motion. She came up again about 4.30 p.m., bringing with her a motion which had the appearance of watery strawberry jam. The temperature was still normal, but pulse rather rapid, and the child appeared to be in the first stages of collapse. There was nothing palpable in the abdomen. Rectal examination revealed a ballooned and empty rectum, and on bimanual examination an ill-defined lump could be felt high up in the abdomen. She was diagnosed intussusception and admitted. Mr. Scott operated at 5.30 p.m. The ileo-cæcal junction was first examined, but showed no abnormality. The gall-bladder was then noticed to be markedly distended, and the liver and spleen somewhat enlarged. The whole of the large gut was examined, but found to be normal. The stomach, duodenum and upper part of jejunum were all healthy, but about half-way along the jejunum the gut was noticed to be in a state of complete collapse. A short distance further on a small intussusception was found, the intussusception being about $1\frac{1}{2}$ inches in length. Within the next foot of gut two more intussusceptions of about the same size presented themselves. In the mesentery of this area of gut a large mass of glands was seen—probably the lump felt bimanually. The ileum was not at all hypotonic and seemed quite healthy. The intussusceptions were reduced and the abdomen closed. After recovering from the operation the child made uninterrupted progress, and is now running about again; but she is a weakly looking child.

I am indebted to Mr. Steward and Mr. Scott for permission to publish these notes.

H. A. H. Harris.

Papers by Guy's Men.

R. P. Rowlands, O.B.E., M.S., F.R.C.S., Three Gastric Cases.—*Lancet*, November 20th, 1920, page 1065.

Montague F. Hopson, L.D.S.Eng., Hemihyperplasia of Face, Jaws and Teeth.—Proc. Roy. Soc. Med., May, 1920, xiii., Sect. of Odontology, page 67.

Montague F. Hopson, L.D.S.Eng., A Mandibular Third Molar situated in the Coronoid Process.—*Ibid.* page 76.

Discussion on the Pathology and Treatment of Dental Cysts.—Proc. Roy. Soc. Med., xiii., Sect. of Odontology, Mr. E. C. Hughes, page 108; Mr. Montague Hopson, page 111; Mr. T. B. Layton, page 113.

A Case of Diaphragmatic Hernia.

The text-books of Surgery allot very little space to the description of Diaphragmatic Hernia. They, as a rule, dismiss it in a few lines, stating that it is a very rare condition which is still more rarely diagnosed during life. They divide the cases into those of traumatic origin and those of congenital origin. The European war must have added greatly to our knowledge of the traumatic cases. In these circumstances it is all the more interesting to know that a case of non-traumatic diaphragmatic hernia has recently been diagnosed and operated upon by Mr. Rowlands in this Hospital.

The patient, T. M., aged 19 years, came up to Out-patients complaining of pain in the epigastrium coming on immediately after meals. His history is as follows:—Thirteen months before admission the patient commenced to have sharp pain in the epigastrium and left hypochondriac region. The pain used to come on from two to three hours after taking a meal. The patient used to vomit, and this relieved the pain immediately. He never had pain apart from meals. Nine months before admission to Guy's he was taken into Rotherhithe Infirmary, the diagnosis being gastric ulcer. Laparotomy was performed, and the stomach was found fixed high in the epigastrium. It was described as having a constriction as though it had been nipped somewhere. No ulcer was found. A ventrofixation having been performed, the abdomen was closed, no diagnosis being made. The patient was relieved for about three weeks after operation. He then began to have pain immediately after meals. He used to make himself sick, and this relieved the pain at first. Soon, however, the pain was not altogether relieved by this device. Then he discovered that by lying on his left side and by eructation he could always relieve the pain.

Physical examination showed a definite sinking in of the epigastrium. The lower ribs were unusually prominent on the left side in front, and they were limited above by a sulcus running transversely at level of the episternal notch. The patient had noticed this for about six months. The examination of the chest showed dulness at left base in front. The X-ray report at Out-patients stated that there was a tight constriction of the stomach in the mid-gastric region which did not allow any food to pass through. The upper half of the stomach was much dilated and pushed the diaphragm above heart level.

Patient was admitted to Naaman under Mr. Rowlands as a case of diaphragmatic hernia. Physical examination in the ward showed the apex of the heart one inch internal to nipple line and no dulness to right of sternum. Percussion gave a tympanitic note at left base behind. The voice sounds on the left side were weak. No borborygmi were heard in the thorax. Mr. Rowlands decided to operate. X-ray before the operation showed "The œsophagus passes down to the level of the lower border of the 11th dorsal vertebra and then turns to the left to join the stomach. The whole of the stomach lies above the diaphragm, the fundus behind, and the pylorus antero internally. The œsophagus enters the fundus at its lowest part. The motility of the stomach is good, and the meal leaves normally, but the duodenum does not seem to follow its normal course."

Operation:—Intra-tracheal ether was administered by Mr. Bonar. The patient was placed on his right side. An incision was made on the left side over the eighth rib. The rib was resected, the periosteum being left. When the ribs were separated an excellent view of the interior of the thorax was obtained. The lung with its covering of pleura was pushed upward, and in the space left between the lung and the diaphragm lay the whole of the stomach, part of the transverse colon, and the spleen. The hernial opening in the diaphragm was to the left of the œsophageal opening and a little anterior to it. The lesser curvature of the stomach was bruised and inflamed, presumably owing to friction from the sides of the opening. After the breaking down of many adhesions the stomach and the transverse colon were reduced into the abdomen. The spleen was reduced last, and this afforded much resistance to reduction. The hole in the diaphragm was sutured and reinforced, and the incision wound sewn up with thread. The patient made an uneventful recovery, and is now perfectly well.

X-ray after operation showed "Large opacity at base of left lung probably caused by pleural thickening (? blood clot) in old hernial sac. The opaque fluid passes through the œsophagus and into the stomach, which is lying in the normal position in the abdomen and which shows no abnormality."

Two interesting points about the operation are as follows:—Firstly, owing to the retraction of the lung, the pleura, which incidentally was much thickened, was not opened, and, secondly, the removal of the eighth rib gave an extraordinarily good view of the thorax, leaving plenty of room for the operator.

My thanks are due to Mr. Rowlands for permission to report this case, and to Mr. Gaymer Jones for the use of his notes.

E. R. B.

Honours.

Capt. A. Sandison, R.A.M.C., Medaille d'Honneur, avec glaives, en vermeil (French). (Announced in *London Gazette*, November 5th, 1920).

Four Cases of Herpes Zoster.

As the Editor of the GAZETTE frequently asks for contributions from general practice, I have thought it might be of interest to record four cases of Herpes Zoster which I have treated during the present year.

Case 1.—Boy, æt. 16, of outdoor occupation with horses. He had been exposed to the wet weather of April this year, and had got wet through and suffered with a cold. There was no other history. When I saw him he had a vesicular rash—well developed on the right chest—in the nipple area and running round intermittently to the angle of the scapula at the back. His temperature was 101°, the axillary glands were enlarged and tender, and he suffered considerable pain—being unable to sleep at night. There were no other features of particular interest to note.

Case 2.—Was a married woman æt. 21, whom I saw at the beginning of June. Again there was no particular history beyond a cold just preceding the rash, which was vesicular in character and situated on the left side below the breast running round with intervals to the back. There was no temperature and very little pain, but considerable irritation, and the axillary glands were enlarged and tender.

In neither Case 1 nor 2 were the throats involved.

Case 3.—Was a woman, married, æt. 34, whom I saw about the latter end of June suffering with a sore throat. The temperature was 100°, the left tonsil was inflamed, with extension to the fauces and pharynx. After some days a vesicular rash appeared involving the left ala nasi and left auricle, giving a lot of pain and irritation, and there was involvment of the eye, with conjunctivitis and frontal headache and photophobia. There is no doubt the Gasserian Ganglion was involved in this patient affecting the first and third divisions—possibly the second.

In commenting on these three cases, they all occurred about the same time, April—June, in a small Warwickshire village during a phenomenally wet season. They have a common history, i.e., "a cold," although in Case 3 alone was the throat definitely infected. Therefore one might conclude the nasal airway and the oral airway to be the portals of entry of some causative organism. I could discover no relation to chicken-pox in these cases.

The cases followed a normal course, recovering in ten days to a fortnight, leaving no sequelæ so far as can be ascertained.

Case 4.—Only occurred this month, in an Oxfordshire village, the patient being a boy, æt. 11, who came to see me on account of a rash on the chest and as to school attendance. The rash was vesicular and well marked on the right chest, axilla and back. There was no temperature or pain, but irritation with enlarged and tender glands in axilla. The boy had had a cold, but the throat was normal. On enquiry I found two people, a man and a child, in the same village (under the care of Dr. Penrose. of Banbury) who had chicken-pox. Dr. Penrose tells me the one case of Varicella in his adult patient was so severe as to make him entertain the thought of Variola. The interest of this case then lies in the incidence of Herpes Zoster in a small village occurring simultaneously with the cases of chicken-pox. The cases are in no way connected, except in so far as they centre round a post office where one case of chicken-pox occurred. Beyond recording the fact, one can deduce nothing other than putting forward the hypothesis of a common origin possibly air-borne.

Since I believe the connection between Herpes Zoster and Varicella was first drawn attention to by a Guy's man, I regarded it of sufficient importance to record—especially the last case.

A. ALAN FORTY.

Shenington,
Banbury, Oxon.
November 14th, 1920.

Reviews.

Aids to Osteology. By Philip Turner, F.R.C.S., 2nd edition (Messrs. Ballière, Tindall & Cox, London) 1920.

The second edition of this small book should prove to be a still greater success than the first. It is unnecessary to emphasise the importance of this subject, which is regarded by the average student as dry and fatiguing, chiefly owing to the uninteresting manner in which it is rendered. Mr. Turner's work is written in an easy and flowing style which does not tire the reader. The Introduction is short and concise, and the remaining chapters contain neither too much nor too little. It should appeal especially to those who wish to revise this subject rapidly after reading one of the classical text-books.

Clinical Methods for Students in Tropical Medicine. By G. T. Birdwood, M.A., M.D., D.P.H., Lieut.-Colonel I.M.S. (Messrs. Thacker, Spink & Co., Calcutta) third edition.

This useful work is mainly intended as a convenient book of reference for students and practitioners in India. Its scope is, however, rather wider than its title would suggest. Besides the ordinary tropical diseases such as malaria and dysentery, many others such as gonorrhœa, diphtheria,

and tubercle are dealt with from the point of view of the clinical investigations which have to be undertaken for their diagnosis. The sections dealing with malaria are contributed by Lieut.-Colonel S. R. Christophers, I.M.S., who is probably the *greatest living authority on the subject*. The whole question of the classification of different types of mosquitoes and the recognition of breeding places is thoroughly explained. There are also a number of notes on making malarial surveys. Throughout the book is written in simple and concise language with very full details for all laboratory processes. It can be strongly recommended for those who are taking up work in the East. J.J.C.

Pass List.

L.D.S. Final Examination,
October, 1920.

*G. R. D. Bradfield.
*L. F. Fouraker.
W. J. Pretorius.
*R. A. Moore.
A. F. Percy.
*A. L. Hyslop.
*C. P. M. Valette.
*M. Braun.
*M. F. Braun.
*E. Clark.
*J. L. de Kock.
*G. K. Jennings.
*C. Glassington.
*F. D. Gratrix.
*H. Greaves.
*W. R. Hibbins.
*C. F. Hudson.
*B. J. M. Keyter.
*P. Krige.
*H. A. F. Leipoldt.
*G. M. Mew.
*J. H. D. Myatt.
*G. Parker.
*S. H. Rands.
*N. B. Wells.
*P. H. Williams.
*G. S. W. Willis.
*T. E. Withers.
*C. B. Wood.
B. C. Woodroffe.
H. G. R. Canning.
A. L. Spencer Payne.
H. Ashling.
C. G. Atkinson.
A. C. Ayling.
S. Bremner.
H. V. Croucher.
S. W. A. Davis.
D. F. G. Dickens.
F. G. Downing.
J. J. du Toit.
I. Freiberger.
R. J. Hooker.
H. L. Ide.
J. L. Lean.
L. Lyon.
E. H. Muir Smith.
C. S. Neame.
A. T. Partridge.
S. W. Southwood.
W. H. Willis.

*Part I. only.

Conjoint Board.

Final Examination, October, 1920.

Medicine.

E. J. Crisp.
P. L. Richardson.
H. A. A. Pargeter.
R. M. Patterson.
M. Maizels.
S. Cohen.
A. Mikhail.
E. C. Faraker.
W. Remington.
T. W. Turner.

Surgery.

M. Maizels.
S. Cohen.
R. M. Patterson.
E. C. Faraker.

Midwifery.

M. Maizels.
G. W. Elkington.
J. F. Jones.
J. E. Wright.
P. Couacoud.
A. H. Shelswell.
M. H. Eid.
S. Sedaros.

University of London.

Third (M.B., B.S.) Examination for Medical Degrees, October, 1920.

Honours.

*F. C. S. Broome.
*M. Coburn.
*Distinguished in Surgery.

Pass.

J. V. C. Braithwaite.
G. P. Lindsay.
W. A. Hawes.
V. E. Lloyd.
E. C. Hinde.

Group I.

James York Moore.
L. Muir Smith.

Group II.

E. H. L. Le Clezio.
H. N. Pritchett.
C. H. St. John.

Football.

GUY'S v. UNITED SERVICES.

Although the coal strike was over before Saturday, November 6th, the day this match was played at Portsmouth, the train service was still far from normal, so our journey to the naval town was somewhat tedious.

The Services, like ourselves, were not at full strength, but as far as regular players go both teams had about equal representation. H. Van Heerden came into the side for Olivier, and a re-arrangement, very cleverly thought out, of the Hospital back division was made, as neither C. L. Steyn or H. Graham-Davies could take their usual places. J. A. Krige and P. K. Albertyn played in the centre with F. W. Reitz and A. Daneel on either wing. This was Daneel's first appearance in the First XV. this year, and he showed if anything improved form, good as he was throughout last season. A. H. Van Zyl was unfit, and F. W. Reitz in the back division, hence R. F. H. Duncan and L. K. Watson completed the pack.

The sailors went away at a great pace, and for about 15 minutes both packs, as a player graphically stated, "belted up and down that bally field as hard as they could go." During this strenuous

period our line had one or two narrow escapes, but after that we had the best of the play. Albertyn made a great centre, and so did J. A. Krige; the latter is always sound, but we had not seen the former in this position: he was remarkably good in every department of centre three-quarter play, he obtained one try this first half, and Duncan got away from a line out and evading all would-be tacklers grounded for a second try. After this came the interval.

The second half opened with another period of "belting up and down the bally field," and then play settled down again. Davies and Kershaw were the Services' halves, and they wanted much watching, especially the latter. L. K. Watson managed to ground the former once or twice. The famous international Service half-backs are superb players, and our own men did well to nullify their cleverness and ingenuity. About 20 minutes of the second half had gone before Krige scored wide out for E. E. Neser to goal with a grand kick. Later Krige scored again after some very fine passing by the Hospital back division. The last try was scored by Albertyn after almost all the backs had handled, and some more than once. Van Schalkwijk goaled, and the final score read Guy's 2 goals 3 tries (or 19 points) to Services' nil.

Van Heerden did very well indeed, and the backs are altogether to be congratulated. Among the forwards Doherty, Shelswell and Watson were particularly on their game, but the whole eight after the initial bustle, which somewhat rattled them, settled down to good football.

Guy's team:—H. Van Heerden, F. W. Reitz, P. K. Albertyn, J. A. Krige, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, A. H. Shelswell, E. E. Neser, C. Marais, R. F. H. Duncan, F. J. Biddle, L. K. Watson, and C. Macintosh.

The record of the Rugby Football First XV. to date is 9 matches played, 7 won 2 lost; 214 points to 12. Three of 12 points against are for a penalty; our line has only been crossed three times.—November 9th, 1920.

GUY'S v. NORTHAMPTON.

Played at Northampton on Saturday, November 13th. There are hard matches and hard matches. This was an adjectival hard match, and no wonder some daily papers called it grim. The match, well-nigh entirely confined to the forwards, almost defies description. It was simply plugging away with boot and push the whole time. A couple of casualties, one to either side, made the game more even still, as our player, J. A. Krige, was a very big loss to the Hospital. He dislocated his shoulder; fortunately it is going on well, but naturally some little time must elapse before he comes into the side again. Krige was tackled before going up for Daneel to score a try, when the damage happened, not a rough tackle by any means. The only other score of the match was a try to Northampton gained by R. Friend. Both teams fought very strenuously for the winning points, but the game ended with the scoring level, 3 points, or 1 try, to either side.

Guy's team:—H. Van Heerden, A. Daneel, P. K. Albertyn, J. A. Krige, F. W. Reitz, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, C. Marais, A. H. Shelswell, E. E. Neser, R. F. H. Duncan, F. J. Biddle, R. Macintosh, and L. K. Watson.

Many old Guy's players the world over, especially perhaps some old Kent County players such as E. Morgan, A. B. O'Brien, P. F. McEvedy, J. P. Jones, H. R. Mullins, S. McK. Saunders, L. B Stringer, &c., &c., may read with interest that Mr. Geo. Harnett, whom they all know full well, recently gave a lecture at a meeting of the United Banks R.F.U. on "Forty Years of Football." In the course of his lecture he stated that football came down to us from the reign of King Henry II. It was in its earliest days a case of Town v. Town with the ball equi-distant, and it had to be taken to the opposing town "any old how" with horses or other means. Mr. Harnett stated that Guy's Hospital Club was the oldest in London, being founded in 1856. Two rules of early "footer" caused much amusement (1) No player may be held and hacked at the same time (2) Though a player may be held in the scrimmage no attempt must be made to throttle or strangle him. Your reporter saw Mr. Harnett recently, and his many old Guy's friends may like to know the very genial lecturer is still as merry as ever.

GUY'S v. CAMBRIDGE UNIVERSITY.

It was a delightful afternoon at Honor Oak Park on Wednesday, November 18th, the setting perfect for the most popular match of the season. The Varsity are always welcome visitors at Honor Oak Park, and none the less so because they rather showed us how to do it to the tune of 2 goals 2 tries (16 points) to the Hospital's 1 goal 1 try (8 points). I think the speed of their centre three-quarters, our failure to hold Craigmile and S. Cook, and the inefficient marking of the former led to our undoing. Several times our defenders got hold of the old Uppingham player, but failed to tackle or impede his run. Probably a difficult runner to stop. Many reasons besides, one heard, a pass dropped here or a holding on to the ball

too long, or a kick instead of a run; but all these things are part of the game. Both sides played remarkably well, and Cambridge the better. They deserved their win because they were always "there," and the handling behind the scrum quite good. Gardiner as "stand off" showed how to get a move on before parting, and always had his line swinging along at top pace before sending the ball to his attacking quartette. Guy's had the best of it for about 15 minutes, and once Graham-Davies with fine dash was almost over. Daneel, sad to relate, had a very bad shake up quite early; no wonder he dropped a pass or two once or twice. Had he been fit he might have succeeded. Hamilton-Wickes opened the scoring for Cambridge, after delightful handling, and Conway converted. At the other end Marais looked all over a scorer, but he was pulled down just short of success. Play, very hard play, in which both packs strove for possession, found Guy's giving ground. Then Gardiner took a very low pass indeed and raced away, S. Cook and Craigmile completing the movement. No conversion followed. Hard at it again, Doherty doing great things, Marais and also Macintosh, but no score came our way, though both Steyn and Daneel did their best. At the other end Van Heerden gave a very sound display. Full of grit, he kicked all the better when seemingly overwhelmed; in fact, the match showed Van Heerden a most reliable and resourceful full-back.

Directly play was resumed Craigmile, who seemed incessantly in the picture, secured from a long line out, made a straight line for a try, and managed to score by the posts. It was a great piece of opportunism. Conway converted. Steyn now and again got off on the left, and at length from a high punt there was some scrambling on the Varsity line which Marais ended by scoring a try. Neser's good shot just missed. The Hospital thus encouraged played up with great spirit, though D. D. B. Cook was only stopped just in time, by Van Heerden clutching his foot. Van Heerden got in a lusty kick or two. Steyn cross-kicked, and Graham-Davies was tackled just outside. Just after he was knocked senseless and carried off, but resumed again with the greatest pluck as soon almost as he woke up. Before the end Hamilton-Wickes got another try, and after a very determined attempt by Daneel Albertyn sent Steyn in at the corner. Neser converting splendidly. Soon after the game came to an end. Graham-Davies gave a very dashing display, but was closely watched. J. A. Krige was somewhat missed. His position was well filled by Albertyn all the same. Bekker, untiring and hard-working as ever, perhaps did a little too much boring through. The Hospital were up against a good side; they never lost heart, and kept going at full steam till the final whistle.

Guy's team:—C. L. Steyn, H. Van Heerden, H. Graham-Davies, P. K. Albertyn, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, C. Marais, A. H. Shelswell, E. E. Neser, R. F. H. Duncan, F. J. Biddle, R. Macintosh, and F. W. Reitz.

Cambridge University team:—H. F. Cockill (Emmanuel), R. H. Hamilton-Wickes (Pembroke), H. W. C. Craigmile (King's), S. Cook (St. Catherine's), D. D. B. Cook (Pembroke), F. A. Gardiner (Pembroke), A. B. S. Young (St. Johns), G. S. Conway (Caius), W. R. F. Collis (Trinity), R. Cove-Smith (Caius), P. A. Batty (Caius), A. Carnegie Brown (St. Johns), T. E. Morel (Jesus), J. H. L. Miller (Pembroke), and H. K. P. Smith (Caius).

GUY'S v. ROSSLYN PARK.

There were so many of the First XV. away from the side at Honor Oak Park on Saturday, November 20th, that it was a little difficult to say who was there. A glance at the team may suffice. The United Hospitals played Edinburgh University on Monday, November 22nd, at Edinburgh. The Hospitals, under W. D. Doherty's captaincy, drew so largely for their side on Guy's that few men felt able to play at Honor Oak Park on Saturday and Edinburgh on Monday, though F. Bekker, J. G. Van Schalkwijk and C. L. Steyn were among the stalwarts that essayed both games.

The attendance was poor when the sides turned out, and they turned out much too late for such an afternoon. The time for the kick-off was 3 p.m., and the ball should, no matter if either team is incomplete, be kicked off at 3 p.m. The time for commencing is published, the spectator pays to see a game commenced at the published time. Good sportsmanship, giving the other fellow a chance to get to full strength, caused the delay, but it is not fair to the fellow who has paid his money, all the same, when the afternoons close in so early. Almost from the kick-off the ball was punted over the heads of the Park three-quarters, and marvellously picked up by Steyn, who sent Williams in. This reverse put the Park on their mettle, and they started a very strong forward game. Someone told them constantly to use their feet, this they no doubt did, and many rushes were initiated. One Guy's man in particular tried to stop them by turning his back on the oncoming tide of men, and when they had passed him shouting to someone else to drop on the ball. For all these rushes we should have scored again several times, but the three-quarter line was not well served and the forwards not quite fast or firm enough in the tight. Close was almost over, a gallant effort, and Steyn had a grand chance, but yards off the

full-back he punted and ran after it; quite useless. This full-back was very fragile and nervous, but he was full of pluck, and many a man with twice his physique has half his courage. At the other end Van Heerden, cool and solid as ever, went down to the footwork splendidly, but he at last had to admit defeat, the visitors through Parkes scoring. Just before this Steyn had to retire. It was reported he had broken his nose; very bad luck; Steyn is experiencing a run of misfortune. One hopes he will soon be able to have another and more fortunate spell of luck.

The second half was scrambling; very little passing was accomplished. Van Heerden, who had come to three-quarter, gave us a straight run or two, and was rewarded with a try. Bekker got a couple of his special subterranean variety. Reitz had gone to full-back, and here he failed to gather cleanly, with the result that the Park through the agency of Campbell got another 3 points. Duncan, Shelswell and Close played well, so did Van Heerden and Bekker, but we were not convincing behind the pack. The three-quarters are so long before they get going full steam. One hopes with regard to outside play the Hospital back division is not allowing finesse to take the place of determination. We want more ginger at present in going for the line, less kicking and more determined running. Graham-Davies and J. A. Krige are no doubt missed from the centre positions, so every allowance in common fairness must be made for those who sportingly fill their places. Final score Guy's 4 tries (12 points) Rosslyn Park 2 tries (6 points).

Guy's team:—H. Van Heerden, H. K. Williams, C. L. Steyn, P. K. Albertyn, F. W. Reitz, F. Bekker, J. G. Van Schalkwijk, A. H. Shelswell, R. F. H. Duncan, L. K. Watson, H. G. Close, L. B. Helder, R. Mackenzie, C. Harvey, and B. Laver.

GUY'S "A" v. ROYAL SCHOOL OF MINES.

Again a weak side was fielded, two forwards being recruited after noon on Saturday, one of whom had never played "Rugger" before.

Almost as soon as play commenced our opposing captain scored under the posts, the kick being successful. From the kick-off our forwards carried the ball to the opponents' "25" line, and after five minutes' play there James scored after Berry had crossed their line twice, but did not get the referee's decision. The Mines' left wing scored wide out.

In the second half our forwards played well together, and after 15 minutes' attacking James scored for Crook to improve after a neat bout of passing. Guy's still held the upper hand, but missed several opportunities through bad passing, and allowed the Mines to gain another try and the victory as the direct result of the bad fielding of a cross-kick. Guy's forwards did extremely well against a heavier pack, but the outsides could not handle the ball with any degree of certainty. Result, Guy's "A" 8 points, Royal School of Mines 18 points.

Guy's team:—J. S. Jacobez, D. A. Newberry, L. Weinberg, F. W. Crook, O. P. James, L. Nurick, S. P. Meacock, R. V. Cookes, D. J. T. Jeans, H. Lewis Phillips, W. A. Mill, E. H. Berry, E. Bevis, R. G. Williams, and Estment.

GUY'S "A" v. R.A.F., UXBRIDGE.

Owing to several scratchings, a weak side visited Uxbridge on November 17th. Guy's played up the hill in the first half, and changed ends with a lead of 9 points, Weinberg, Meacock and Williams obtaining tries. On the resumption of play the Depôt scored twice in quick succession, their second try being the result of an intercepted pass on their own "25" line and a run nearly the length of the field. Although four reserves figured amongst the forwards, our pack finished the game with great dash and determination, their efforts being rewarded by two more tries by Close and Meacock, the latter being converted by Harvey. This, however, did not happen before the Depôt M.O. crossed our line for the third time. Result, Guy's "A" 17 points, R.A.F. 11 points.

Guy's team:—J. S. Jacobez, H. K. Williams, L. Weinberg, R. Jarman, O. P. James, E. C. Seward, S. P. Meacock, P. Harvey, H. G. Close, R. McKenzie, R. V. Cookes, R. Amm, Reeders, G. M. Stoker, and C. Ive.

GUY'S "A" v. KING'S COLLEGE "A."

Played on the King's College Ground at Wormwood Scrubs, Guy's played one man short owing to a misunderstanding; a very even but dull game resulted, which King's won 4—2. The forwards were the weak spot, but were handicapped by there only being four. Crisp and Wayman scored for Guy's.

Guy's team:—Mackeith, Fripp, Robertson, Wooldridge, Danino, Hewetson, Jones, Crisp, Nicolai and Wayman.

JUNIOR A.F.A. CUP v. OLD TIFFINIANS.

This was played on a public ground at Kingston with various small games of football encroaching at times on our pitch. The result, a draw 1—1,

was very disappointing, as our opponents got their equalising goal on time, when it was practically dark. Had the inside forwards displayed a little more dash and shot better we must have won easily. The defence was quite satisfactory, and also the combination of the forwards until they got near goal. Gonsalves scored for Guy's.

Guy's team:—Mackeith, Robertson, Fripp, Wooldridge, Danino, Hewetson, Smith, Crisp, Nicolai, Gonsalves and Wayman.

Hockey.

GUY'S v. UNIVERSITY COLLEGE.

Guy's sustained their first defeat on Saturday, November 13th, being beaten by University College by 7 goals to 3.

The winners fielded a strong side which included six or seven members of the London University team which recently beat the United Hospitals by 14 goals to 1.

Guy's did well to bring the score to three all about twenty minutes before time, but for the remainder of the game University College had matters their own way and added four goals to their score, making the total 7 to Guy's 3.

The chief feature of the game was the play of T. R. Kirkpatrick, the University College centre-half. He never made a mistake, and his forwards made full use of the opportunities he gave them, Brain scoring four goals and McCullum 3.

For Guy's Graham-Bonnalie scored 2 goals and Hunt 1. Three points should be mentioned regarding the weakness of Guy's team. First, Baugh, whilst stopping many hard shots in goal, seemed to fail to know when to stick in goal and when to run out; secondly, the half line, which is good in defence, must learn to play an attacking game: thirdly, the forwards were poor in the circle and failed to avail themselves of the opportunities which accrued from their good combination.

Guy's team:—C. V. T. Baugh, C. G. Bowen, W. F. Hurdle, H. Slater, J. R. A. Moore, S. C. Olver, W. S. Hunt, J. V. Schollum, F. E. Graham-Bonnalie, B. M. Tonkin (capt.), and E. G. Smallbone.

GUY'S v. DULWICH.

Perhaps the best match so far this season was played against Dulwich on their ground on Saturday, November 20th.

The sides were evenly matched, and half-time was reached with the score one all. G. L. Pemberton having scored for Dulwich and B. M. Tonkin for Guy's.

Early in the second half Dulwich scored from a penalty bully—a most unfortunate affair—and a few minutes later A. L. Pemberton increased their lead to 3—1.

Guy's now took the initiative, and the forwards carried all before them, some especially neat work being seen on the right wing, but so well did the fearless Dulwich goalkeeper and Porter, their centre-half, play that Guy's only managed to add one more goal (scored by J. V. Schollum) when time was up with Dulwich winners by 3 goals to 2.

Guy's team:—C. V. T. Baugh, C. G. Bowen, W. F. Hurdle, H. Slater, J. R. A. Moore, S. C. Olver, W. S. Hunt, J. V. Schollum, F. E. Graham-Bonnalie, B. M. Tonkin (capt.), and E. G. Smallbone.

B XV. Fixtures.

Dec.	8.	St. Mark's College, Chelsea	H.O.P.
	11.	St. Dunstan's College, Catford	Away
	15.	Royal Veterinary College	H.O.P.
	18.	Old Stortfordians	Away
Jan.	22.	Whitgift School	Away
	26.	Bart.'s "B"	Away
	29.	King's College School, Wimbledon	Away
Feb.	2.	R.N.C, Greenwich	Away
	5.	Old Alleynians "B"	Away
	9.	Bart.'s "B"	H.O.P.
	11.	Exiles "A"	Away
	23.	R.M.A., Woolwich	Away
Mar.	2.	St. John's College, Battersea	Away
	5.	King's College	Away
	12.	Hong Kong and Shanghai Bank	Away
	16.	St. Mark's College, Chelsea	Away
	19.	Old Blues "B"	Away
April	2.	Edgware "A"	Away

Nomads' Fixtures.

Dec.	1.	Bart.'s "C"	Away
	11.	G.W.R., Paddington	Away
Jan.	5.	Rosslyn Park "A"	H.O.P.
	12.	Goldsmith's College, New Cross	H.O.P.
	15.	Old Dunstonians	Away
	26.	St. Thomas' Nomads	H.O.P.
	29.	Old Alleynians "C"	Away
Feb.	2.	Bart.'s "C"	H.O.P.
	5.	Park House "B"	Away
	16.	St. Thomas' Nomads	Away
	19.	Dulwich 3rd	Away
Mar.	19.	London Scottish B	Away
	26.	Hong Kong and Shanghai Bank "A"	Away

Arthur Durham Travelling Scholarship.

The Arthur Durham Travelling Scholarship has been awarded to Mr. Grant Massie.

November 25th, 1920.

Ed.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

A HOST of old Guy's men will have read with regret the news, announced in the *Times* on Tuesday last, of the death of Sir Frederick Taylor. His genial temper and his exceptional capacity as a teacher endeared him to the hearts of all his students. But his influence was felt far beyond the wards of the hospital to which, in so generous a degree, he devoted his conspicuous talents as teacher and physician. His book on Medicine has carried his fame to all the medical schools of England, and not many years ago his professional brethren marked the esteem in which they held him by electing him President of the Royal College of Physicians.

His eldest son, now Sir Eric Taylor, was a resident here at Guy's in comparatively recent years, and will be remembered by many of his contemporaries, some of whom are still with us. To him and to his sister we offer our sincerest sympathy.

NOT long ago we wrote of the museum and attempted to indicate certain improvements that might be made. More especially we urged the cataloguing of the wax models of skin diseases. Since then Dr. Barber has written pointing out that there is, as a matter of fact, a catalogue of these specimens and a very good one too—written by Dr Fagge when he was curator of the museum. We are pleased to hear of its existence. Our attempts to find it have always failed and a recent search, with official assistance was equally unsuccessful. It is a pity that the catalogue cannot be kept in its proper place and we should like to put forward an appeal to all who use the museum and the catalogues to take the trouble to replace everything after use. The other catalogues are rarely in their appointed positions and it is not uncommon to find the specimens themselves put back upon the wrong shelf—sometimes quite a long way from their proper companions.

Dr. Barber further tells us that he has the skin models in hand. He does not wish to re-write Dr. Fagge's admirable catalogue but he is revising it and bringing it up to date. He hopes that all the specimens will be properly labelled and catalogued before very long. This is good news and we only hope that the revised catalogue will be readily available. This will only be possible if users of the museum will take the same care of all museum specimens and catalogues as they would of their own books and property.

Apparently wax modelling is a lost art. Dr. Barber tells us that there is no one now who can do really good work—certainly no one who

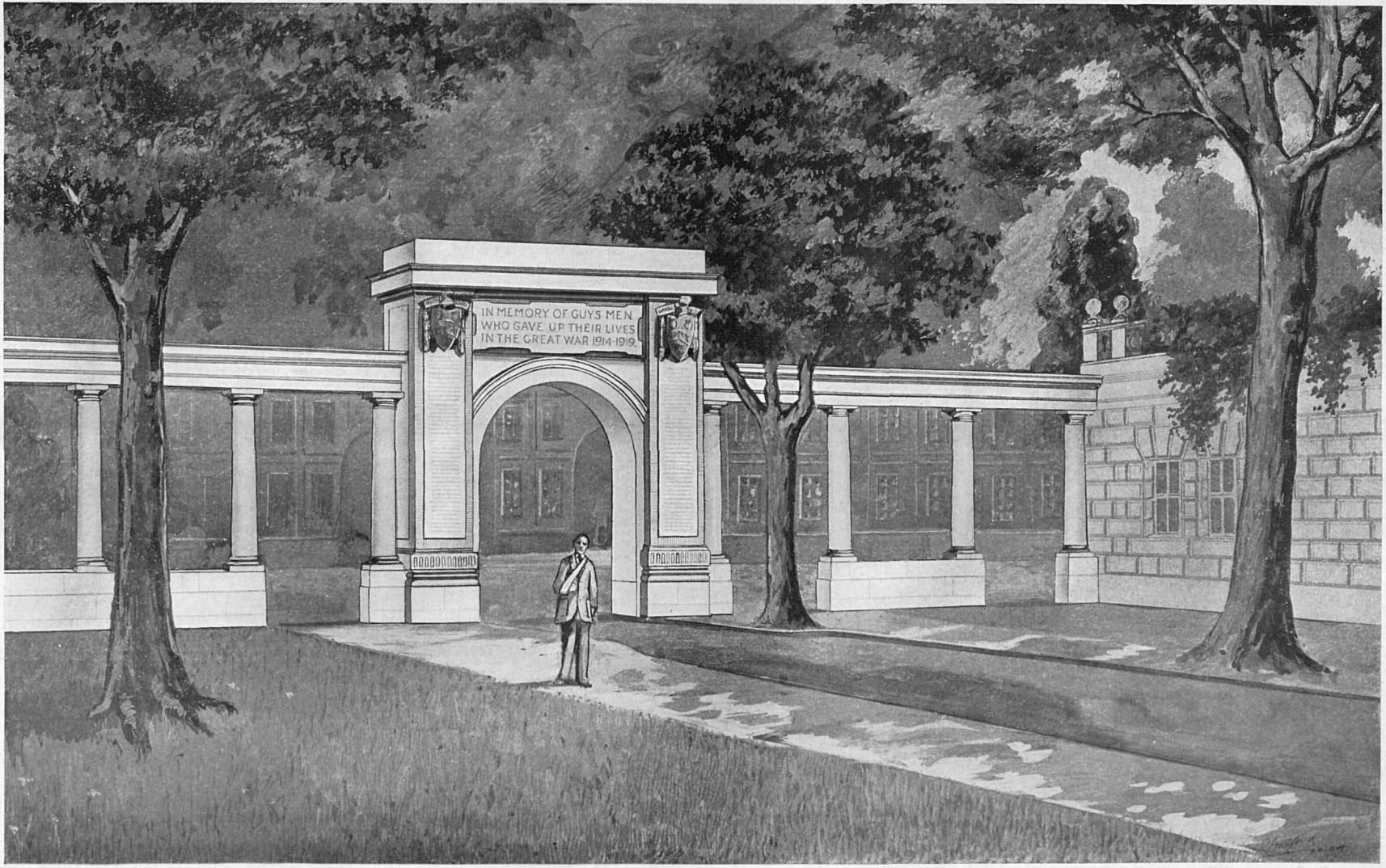
can produce models fit to rank with the masterpieces of Joseph Towne.

AT last we are able to publish the drawing of the war memorial which we promised to our readers so long ago. The work has already begun and it should not be long now before it is completed. It is to consist of an Arch and Columnar Screen stretching across the roadway between Hunt's House and Guy's Buildings. Stone from the Isle of Portland is being used and about 110 names will be carved upon panels worked in the stone, and the Arms of the Hospital will be modelled and carved at the head of each of these panels. The structure is being executed by the Hospital Works Department from the design by Mr. William J. Walford the Hospital Architect who is to be congratulated on producing a piece of work of considerable beauty and at the same time in keeping with the adjoining architecture.

THE Physical Society has made an excellent start. The meetings have been well attended, and the discussions have for the most part been both lively and instructive. A little more organization is required to make the meetings really satisfactory. At present they take too long. The cases on clinical evenings are shown at 8 o'clock and the discussion usually goes on till 11, the result being that the cases discussed last suffer from interruptions caused by members going out to catch their last train home. We believe that this could easily be remedied if Ward Clerks and others showing cases would take more trouble in preparing their cases. On Tuesday last another most admirable demonstration was given at Lambeth Infirmary. There some twenty cases were presented, and a meeting certainly larger than the average Physical Society meeting was able to see all the cases quite thoroughly in three-quarters of an hour. For the rest of the time Dr. Stebbing talked about the cases. And how well he talked We wish that those who show cases before the Physical Society would take a leaf from Dr. Stebbing's book. He displayed a very complete knowledge of all his cases without once referring to his notes. It would be unreasonable to expect so high a standard from a ward clerk, but surely the Society has a right to expect its members to know their *one* case thoroughly. Most men by taking a little trouble could show a case quite well without reference to notes. But let them use notes by all means if they will only refrain from attempting to make an extemporary abstract of a long, complicated and probably illegible report. The Physical Society is a serious Society. It is a training ground for those who will later on show cases before other distinguished medical societies. Such societies would not tolerate the treatment meted out to the Physical Society by many members who have shown cases during the present Session.

The example set by Dr. Stebbing at Lambeth might be followed in another respect with advantage. Short abstracts were placed beside each patient. These were very brief (they are in fact reproduced on page 438 of this GAZETTE). If such abstracts were prepared for all cases shown on Clinical evenings, the time spent up in the Theatres might be reduced by at least half an hour. And would it be possible for typed copies of these abstacts to be available for all members? We commend this suggestion to the Secretaries.

WHILE on the subject of the Lambeth demonstrations, we should like to say how much they have been appreciated, and to express the hope that they may become permanent and, if possible, more frequent. There is no question as to their value and great popularity. The demonstration on Tuesday last was perhaps even better than the first, and certainly the organization was more satisfactory.



GUY'S HOSPITAL WAR MEMORIAL.

The University of London correspondent to the *Observer* has been drawing attention to the fact that the University Football XV. suffers from the absence of hospital men who prefer to play for their hospital. Inasmuch as hospital football is older than University football, we suppose that this is inevitable. The traditions behind the hospital clubs are so powerful that few men are likely to be attracted to play for the University when their hospital side requires their services. Moreover, a very large number of medical students in London are not Undergraduates of the University. Many Universities are represented, and quite a large proportion belong to no University. Of course the hospitals are Colleges of the University, and a rather anomalous position is thereby created. We think that if the University wishes to play corporate games the representative teams should be selected from those who are strictly speaking its undergraduate members.

The University of London has always had great difficulties to contend with in stimulating corporate life on account of the distribution of its constituent colleges. In order to overcome in some measure these disabilities it is now proposed to form a University of London Union Society with premises in some central position. The idea is that the Union would be the natural centre of the social side of university life. The existence of suitable club rooms would encourage members to attend debates and other functions which are now only supported by an enthusiastic minority. We publish elsewhere a letter which has been sent out by those responsible for the inception of the scheme. We believe that it is a step in the right direction and we hope that it will have the support oi all Guy's men. Forms of application for membership may be had from either of the Guy's representatives whose names appear at the foot of the letter on page 441.

Our attention has recently been drawn to the inconvenient hour at which autopsies are held. At 2 o'clock in the afternoon it is possible for very few men to attend the post-mortem room. It would, no doubt, be difficult to make any very radical change in the hour, but if P.M.'s could start, say at 1.30 p.m., it would be possible, by starting punctually and taking the obviously interesting cases first, to enable a much larger number of men to see the immense quantity of interesting pathological material that passes through the hospital every year.

If such a change necessitated altering the hour at which clinical lectures are held so much the better, 1.30 p.m. on a Monday is quite impossible for all men in the wards except the members of the firm whose physician or surgeon is lecturing. For men who play games 1.30 on Wednesday is little better, especially in the winter. The right time for these lectures would, we feel sure, be 12 noon. This is a time when men are turned out of the wards and have as a rule nothing much to do. Such classes as are held at this time are always well attended. The afternoon clinical lectures often draw a somewhat meagre audience—an indication rather of lack of opportunity than lack of enthusiasm.

We are glad to notice that the Guy's Hospital Ladies Association is reverting to its pre-war custom of organising dances in the Court Room with a view to raising a fund for the endowment of cots. Especially would we draw the attention of those who have children of their own or whose friends and relations have children, to the juvenile dance to be held on December 22nd from 7 to 11 o'clock. The tickets are 10s. each and can be obtained from Mrs. Rowlands (12, Queen Anne Street), or Mrs. Eason (Guy's Hospital).

THE NIGGERS.

TIME TABLE FOR CHRISTMAS DAY.

11.30 a.m. Parade and Photograph.

12 noon.	Eye Ward.	4.10 p.m.	Charity.
12.20 p.m.	Mary.	4.30 „	Dorcas.
12.40 „	Esther.	4.50 „	Luke.
1.0 „	Queen.	5.10 „	Naaman,
1.20 „	Bright.	5.50 „	Job.
2.0 „	Stephen.	6.10 „	Lazarus.
2.20 „	Addison.	6.30 „	Lydia.
3.0 „	Out-Patients.	6.50 „	Martha.
3.30 „	Evelyn.	7.10 „	Cornelius.
3.50 „	Patience.	7.30 „	Astley Cooper.

The Physiological Society.

A MEETING of the Society was held on Monday, 22nd November, 1920, Professor Pembrey in the chair. Mr. MacKeith read a paper on "The Origin of Life," and a very spirited discussion followed. Mr. MacKeith spoke of the earth becoming inhabited in one of three ways. Either by two planets coming into contact and living material being precipitated on to our planet, or by mechanical construction of living cells from non-living cells, or by the handiwork of some higher power. The meeting resolved itself into two schools, the mechanists and the vitalists. Arguments were put forward for both theories and the Speaker asked to be allowed to put a resolution to the House. This was put to the vote and carried. He proposed: "That in the opinion of the Society, living matter has been, and possibly now is being formed from non-living matter, by those same chemical and physical laws which govern non-living matter."

The motion was *not* carried by 32 votes to 11 votes.

Professor Pembrey proposed, and it was carried unanimously, that the result of the motion should be communicated to Dr. Fison. This has been done.

Theology was touched on at times but it was ruled out of order.

The meeting closed with a vote of thanks to the speaker and chairman.

Forty-nine members were present.

A meeting was held on Monday, 29th November, Professor Pembrey in the chair.

Mr. Warner read a paper on "Alcohol," and a keen and interesting discussion followed.

The discussion ranged around the primary effect of alcohol, whether it was stimulation or inhibition. The arguments for inhibition were that the higher centres were inhibited, removing any restraining influence on the motor centres. Those for stimulation were that the higher centres became unduly stimulated, resulting in fatigue of the nerve cells. All agreed that the secondary condition was one of fatigue. It was recorded how the influence of alcohol brought out all that was brilliant in some people. Instances of surgical and poetical work were given, and of the brilliance of some political and after-dinner speeches.

The meeting closed with a vote of thanks to the speaker and chairman.

Sixty-three members were present.

The last meeting of the term was held on Monday, 6th December, 1920, Mr. Ryffel in the chair.

Dr. Fison's reply to the Society's communication of 22nd November was read. He said that if he had been present he would have found it difficult to vote either for or against the motion without suggesting an erroneous view of his own position. He would most probably have asked the chairman's permission to move an amendment, the terms of which would have been:—

"That while the physical and chemical actions that occur in living cells and tissues, and to which their growth is exclusively due, are identical with those actions as examined in the laboratory, the phenomena of life can only be satisfactorily described by assuming these actions to be controlled and directed by other forces that are only found in conjunction with living matter."

Mr. Shaw read a paper on "Starvation," and on conclusion asked the chairman to explain what occurred in a diabetic case during starvation. The chairman's words were eagerly listened to.

The effects of vitamine absence during starvation were discussed, and it was pointed out that during total absence of food the body draws on its own tissues which supply the necessary vitamines. During administration of small quantities of food the absence of the anti-scorbutic factor was soon felt and scurvy resulted. A recent case, very much before the public, was cited. The direct cause of death during starvation was given as syncope.

The meeting closed with a vote of thanks to Mr. Ryffel and the speaker.

Fifty-five members present.

The Secretary has practically all the subscriptions, but he would ask any members who have not paid to do so as soon as possible. The next meeting will take place on 10th January, 1921.

TRISTRAM WOOLDRIDGE, Hon. Sec.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Clubs' Union Records.

DEAR SIR,—Within the next few weeks a new and standard, and, moreover, symple system of book-keeping will have been put into operation among the several and various Constituent Institutions of the Clubs' Union—not only, I believe, on the sporting side but also upon the intellectual—and past secretaries will, I think, agree that the step is in the right direction. But, the question arises, does it go far enough? And I would suggest that it could be extended.

The financial records are admittedly of the utmost importance to the Clubs' Union and the Committee of the Institution concerned, but not of great interest to the playing member, whereas the minute records would surely prove interesting reading to every individual, and are almost as essential as the financial record.

Could not the Clubs' Union then issue a well bound, named and numbered minute book to be kept by the Honorary Secretaries, and eventually, when filled, placed in the Wills Library?

Were this put into effect a valuable record would, in time, be established in the place of, as at present, the rather unsatisfactory and somewhat bald (though essential) record of the Year Book. Furthermore every member should have the right of access to the records of the Club, and this would then be possible—the minutes for his "playing" year being made available by the member giving fourteen days' notice to his Committee.

I believe that the Rugby Football Club is the only constituent whose records are available and approaching continuity for a number of years, and I would suggest that, with the success of Guy's in the field of sport since the war, now is the time to lay the foundations of a permanent record.—I remain, Sir, Yours faithfully,

JAMES R. A. MOORE,
Hon. Sec. Hockey.

Guy's Hospital,
S.E. 1.
November 26th, 1920.

Herpes and Varicella.

DEAR SIR,—The following cases of herpes varicella coincidence have occurred at different times in my practice.

A man, æt. 40, who as far as he knew had not had chicken-pox, had an attack of herpes zoster over the right supra-orbital nerve; on the 15th day afterwards his son, æt. 9, and on the 16th day afterwards his daughter, æt. 10, developed chicken-pox.

A man, æt. 45, who as far as he knew had not had chicken-pox, had an attack of herpes zoster over the right small sciatic nerve; on the 17th day afterwards his daughter, æt. 17, developed chicken-pox. A girl, æt. 13, had an attack of herpes zoster round the left half of her waist; on the 15th day afterwards, her two younger sisters developed chicken-pox, and the first patient did not develop it then or later.

During the first two cases I was not attending any other cases of chicken-pox, during the third there were several cases in the schools, but in these days of the movies and crowded transport it is not easy to trace sources of infection.

The article on varicella in Pfaundler and Schlossmann's Diseases of Children says that pressure of clothing may cause such an arrangement of the varicella vesicles that they may be mistaken for herpes zoster, quoting a case that Von Bókay reported in 1892, which was treated as herpes zoster, only to lead later to an outbreak of varicella in the same family; even with such authority I don't think I will go back on my diagnoses of herpes zoster in the above cases.—I am, Yours faithfully,

G. LEWIN.

South Croydon.

A Correction.

DEAR SIR,—Allow me to point out a slight inaccuracy in my report on the case of "Hepatitis and Myocarditis with Anasarca and Ascites."

"I gave him Liq. Morphia with Tr. Digitalis a.a ½ oz." This should read *half a drachm*, afterward increased to *one drachm* of each for a dose. Not 1 oz. Pulv. Jalapæ Co. but 1 drachm. Thanking you for your courtesy in publishing my report.—I am, Yours faithfully,

W. H. SPURGIN.

Newcastle-on-Tyne.
November 29th, 1920.

Change of Address.

W. H. Cellier, c/o W. M. Cellier, 9, Welgemund Street, Gardens, Cape Town, South Africa. (Temporary.)

A. Ernest Sawday, M.B., B.S., c/o D. Coleman, 1 Grove Terrace, Osmaston Road, Derby.

Clinical Demonstration at Lambeth Infirmary.

Secondary Carcinoma of Liver.—William T., aged 68 years. Patient, who was once a heavy drinker, has had abdominal indigestion and wasting since 1919. He has never vomited but for many months last winter had repeated attacks of diarrhœa, but has had none for some months now. He is extremely emaciated. The liver is very large, hard and irregular. There is a smooth hard swelling under the left costal margin which may be spleen. Nothing abnormal can be detected by rectal examination; the blood count normal and Wassermann reaction negative; no sugar in his urine and no excess of fat in the stools.

Squamous Carcinoma of Neck.—William B., aged 56. Patient states his illness started in June, 1920, with a small swelling on right side of neck which gradually disappeared, and a month later (July), a swelling appeared on the left side of the neck. The swelling gave rise to no pain or inconvenience until its size hindered the movement of the neck. Patient has a large fixed ulcerated malignant mass on the left side of the neck. No primary growth can be found in the ear, nose, pharynx or larynx. Microscopic examination show the tumour to be a squamous carcinoma.

Advanced Carcinoma of Urethra.—James D., aged 59 years. Illness started in April, 1920, with pain in right testicle and retention of urine with overflow. When first seen a fortnight later patient has a large hard fixed swelling at base of penis and scrotum and filling in the pubic arch. The growth extended very rapidly, the glands became enlarged and ulcerated early, and now there has been extensive destruction of penis and scrotum. Patient has severe cachexia.

Advanced Carcinoma of Penis.—George P., aged 80. Illness started with ulceration of the penis in 1916. He was not admitted to the Infirmary until November, 1920. The penis has disappeared and there is extensive carcinomatous ulceration of scrotum with enlargement of inguinal and iliac glands. The liver is not enlarged and there is little cachexia.

Sweeps' Carcinoma.—Thomas B., aged 68 years. Patient worked as a sweep up till July, 1919, when he stopped work because of the soreness and swelling of his scrotum. Patient has extensive malignant ulceration of the scrotum with enlargement of the inguinal glands. The liver is not enlarged and there is not a severe degree of cachexia.

Spastic Paraplegia.—Louisa L., aged 58 years. Patient's illness started with loss of power in legs, in 1915, and she has been bedridden since spring of 1917, and the contractures have gradually increased since that time. She has spastic paraplegia and spastic paralysis of the left arm. The hip and knees are both strongly flexed and turned towards the patient's left, and the limbs cannot be straightened. The Wassermann reaction is negative in blood and C. S. Fluid.

Chronic Adrenal Insufficiency.—Sarah F., aged 69. Patient is unable to give any history owing to mental disorder. She shows severe anæmia, weakness and pigmentation. The latter is most marked on the trunk, particularly round the waist, but is present all over the body, and is present in small spots on the back of the hard palate. Urine has trace of albumen; sp. gr. 1010. Blood count = Hb. 30 per cent.; reds, 3,750,000; colour index, ·4; whites, 7,000.

Sclerodermia.—John E., aged 23 years. No family history of the disease. Had infantile paralysis when 6 years old. Never noticed anything the matter till three months ago when he was told by a barber that he should see a doctor because of his skin. Patient has sclerodermia all over his body, it being most advanced on the trunk and neck, where he has the "hide bound" condition characteristic of the disease. He is very liable to urticarial eruption.

Syphilis, Rupia.—William E.—Patient says he had chancre four months ago followed immediately by sore throat. Present eruption on right arm started 6 weeks ago. The ulcers are typical rupia with "limpet" scabs.

Gout, Ankylosis of wrists.—Robert L., aged 48. Patient had the first attack in his feet when 20 years old, and has had numerous recurrent attacks. Patient shows extensive ankylosis of carpal and tarsal joints, and much destructive arthritis of knees. There is one tophus in left ear.

? Tuberculosis of Skin.—Henry Q., aged 72 years. Eruption started on left wrist in April, 1919. There is a scar on left wrist, but patient can give no information about it. The sore was treated by Ung. Hyd. Ammon. and disappeared by November, 1919. Present eruption started on the site of the old one a month ago.

Tertiary Syphilis.—Henry M., aged 44 years. No history of infection. Illness first started with sudden facial paralysis and internal ear deafness on the left side, in 1910, followed in three months by facial paralysis and deafness on the right side; within a year he was seen again with tertiary ulceration of nose and palate, and in 1913, with gummatous ulceration of foot and leg. He now shows tertiary osteitis of bones of skull and face, facial paralysis and internal ear deafness.

Arthritis Gout.—John C., aged 75. Patient had an acute attack of gout in his right great toe joint when he was thirty years old. Since that time he has had frequent attacks, and nearly all his joints are affected. Patient shows advanced gouty changes

in hands, feet, wrists and knees. There are numerous tophi on hands, wrists and ears.

Achondroplasia.—William Alfred P., aged 50 years. Patient shows all the typical features of the disease. The head is large and square with large lower jaw. The limbs are very short, and X-rays show that the epyphyses are relatively large and irregular in shape. He has always been able to earn his living as a shoemaker. He is admitted to the Infirmary suffering from neurasthenia.

Congenital Syphilis.—Rosetta S., aged 58. Patient has had many syphilitic lesions, and has had an amputation through the thigh for syphilitic ulceration of the leg. The lower incisor teeth are of the Hutchinson's type, and patient has characteristic deformities of skull, nose and tibiæ and internal ear deafness.

Spastic Paraplegia, Contractures.—Emily D., aged 51 years. Illness started early in 1914, with weakness of legs and inability to walk; slight contractures were already present on her admission to the Infirmary, July, 1914. She has complete spastic paralysis of both legs with severe contractures of the legs and knees. The right knee has complete, and the left knee partial backward dislocation of the tibia, and adductor spasm has produced a scissor leg deformity.

Congenital Syphilis.—Margaret Matilda G., aged 19. Patient has a very good set of Hutchinson's teeth, and she has been deaf since infancy. She has no other signs of syphilis except a strongly positive Wassermann reaction. She has just given birth to an apparently healthy baby; the blood from the umbilical cord gave a negative Wassermann reaction.

Spontaneous Fractures of both Femurs.—Angelina H., aged 69 years. Patient had left eye removed for "cancer" at an eye hospital, in 1912. In May, 1917, she was admitted to the Infirmary with a spontaneous fracture of the subtrochanteric region at the shaft of the left femur. This joined by bony union and she left the Infirmary in December, 1917, walking well. On 28th November, 1920, patient slipped and fell to her left side fracturing the right femur as she fell. She has a subtrochanteric fracture of the right femur. X-rays show that both these fractures are absolutely transverse, the bone having the appearance of having been sawn across at the level of the break. The patient is in good general health and shows no other signs of secondary deposits.

Tabes Dorsalis, Charcot's Shoulder.—Louisa J., aged 59. No history of syphilis. Patient has had typical tabes dorsalis for two years. Left shoulder first showed the changes of Charcot's disease in July, 1920. There is now complete disorganisation of the joint and the bones can be moved on one another in any direction.

Notes on a Year's Work as Ship's Surgeon.

BY H. W. WEBBER, M.S., M.D. Lond.,
Late Surgeon P. & O. Steam Navigation Co.

HAVING recently completed a year's service at sea and returned to practice, it seemed to me that a brief account of the work would be interesting and perhaps dispel the commonly received impression that the ship's doctor has "nothing to do." Of course, my experience came at an exceptional time, as the ship was in Government service as a transport for repatriated troops and emigrants, but it appeared to me that the work on board ship is very much what the surgeon cares to make it, and a man with an interest in his work can find plenty to occupy his time and yet enjoy the social amenities of ship-board and the ever-changing panorama of Nature.

I would put forward to the newly qualified man the desirability of a sea-voyage before settling down in practice. He will have completed five years of hard work to obtain his degrees, and a rest and change will be beneficial to both brain and body. He will probably not get the chance again for many years, if ever. Once his brass-plate goes up he is more or less tied to it—unless possessed of private means—until the day it comes down, and no one can understand the widened outlook on life given by a long sea-voyage until he has experienced it.

As an old Guy's man who settled down immediately on qualifying and knew nothing of the world until a year or so ago, I strongly recommend my fellow Guy's men to take my advice and see it while they can.

Nor is the work devoid of interest, as I shall presently show, or badly paid. As Surgeon in the P. and O. line I drew £28 per month, and in addition made about £120 in fees from passengers, while no housekeeping expenses troubled me. Practically, I consider the year was worth £600 at the lowest estimate.

As a training for general practice the young medical man will find it most useful. He leaves his hospital with little knowledge of the kind of cases he will meet with as a general practitioner, and here he will find that experience of the treatment of minor diseases which he requires. He will meet men and women, see something of the might and extent of the British Empire to which he belongs, and realise, as Rudyard Kipling says, "What do they know of England, who only England know?"

Colombo, Bombay, Cape Town, Durban, the Suez Canal, the Mediterranean, and the Canaries are sights and experiences not to be met with once one is settled down, while further East Australian ports (Sydney, Adelaide and Melbourne) and New Zealand harbours (Auckland and Wellington) are a revelation to the stay-at-home Englishman.

Should he go by the Western route, usually starting from Liverpool, he will find the busy Atlantic before him, and plenty to interest him in the Panama Canal and America or the West Indies before crossing the Pacific to New Zealand.

Now as to the surgeon's daily work. The normal routine is somewhat as follows. Attend in the surgery at 9 a.m. and see any sick of the crew; this being finished he will attend sick passengers, either there or in their cabins, usually the latter. At noon he, in most passenger ships, makes a daily report to the captain on the sick list of the crew and any special cases among the passengers. His work is then done, except for a short evening attendance at the surgery at 5 p.m., and treating any casual cases in crew or passengers. There is provided in all ships now a hospital on the poop-deck where infectious or suspicious cases can be isolated.

I kept a record of all my cases while at sea, and find that the bulk of the work is much the same as in ordinary general practice. Should the surgeon happen to know of a sure cure for sea-sickness he will be much in request among the passengers.

The common troubles of life—dyspepsia and constipation—are commonly met with, and, believe me, the practitioner who can rapidly and permanently cure these simple ailments will soon make a reputation for himself, either at sea or ashore. Boils are very prevalent. I found the best treatment was to paint them with a strong tincture of iodine.

Septic wounds of the hands are frequent, especially among the engine-room department of the crew. I had to operate under an anæsthetic ten times for badly poisoned hands, usually arising from an infected blister while at work. Cuts, lacerations, contusions and sprains are of almost daily occurrence, especially when the ship is rolling at sea. Sore throat of catarrhal or follicular type is often met with. I treated 16 cases of measles, three of scarlet fever, one of erysipelas, and two of chicken-pox during my second voyage, while influenza epidemics twice put the ship into quarantine. I had to perform the operation for strangulated hernia once, and a colleague of mine had to open the abdomen of a child and release an impacted intussusception. Cases of child-birth are by no means infrequent (I attended one in Plymouth Sound). The ship surgeon has to be a dentist also, and one becomes, if skilful, in great demand for extractions.

A working knowledge of the usual diseases of the tropics is necessary, and I recommend that a copy of Manson's or similar work on tropical diseases be read in one's spare time. I met with many cases of malaria, and at Sierra Leone five cases of infection by Cordylobia Anthropophaga, as well as cases of dysentery and of skin disease of various kinds. Venereal disease is frequently met with after leaving port. Chest troubles of bronchitic nature are common in the colder latitudes, and I met with two cases of lobar pneumonia, one of generalised type and fatal.

The surgeon must be prepared to treat cases of heat-stroke, an occasional case of epilepsy, and deal with head injuries. I had one case of fractured base, and scalp wounds of all degrees of severity.

Children are numerous as a rule, as travellers take their families with them, and proficiency in handling the little people's ailments is desirable. Fractures are not uncommon. I met with two cases of fractured ribs, and one of the tibia and fibula, while burns and scalds are by no means unusual. A 1 per cent. picric acid solution will be found the best application.

It will be readily seen how excellent a training for general practice is the work of the ship's surgeon, and I am sure that anyone who decides to "sign on" will never regret the step.

Malaria.

AMONGST the many who have written on the subject of malaria I regret that some who did most useful, though unostentatious, work as regards malaria have not expressed their opinions.

This may possibly be due to the fact that the views of many experienced in Tropical diseases did not coincide with those of the official Army experts. Without taking upon myself to suggest anything original, I venture a few practical points on the treatment of malaria as it is found in England amongst those returned from our Eastern Expeditionary Forces.

It is not my intention to discuss the pathology or symptoms as these can be obtained from a text book on Tropical diseases. The forms of malaria that at present exist in the United Kingdom are chiefly the benign tertian, and the so called malignant subtertian. The importance of the sub-tertian is the fact, that, especially in cold weather, the patient who is suffering from æstivo-autumnal malaria is liable to attacks of cerebral malaria, which may be mistaken for some other form of cerebral lesion.

In these cases the diagnosis is important as unless quinine is exhibited the patient will die.

In all cases where one is called in to see a man who has gradually become unconscious, the friends should be asked in what part of the world the man served during the War. I especially mention this point as in England I have been called in consultation to similar cases.

As regards treatment of malaria. In benign tertian a solution of Quin. Sulph. gr. v., t.d. orally is generally sufficient to stop the attack. In cases where owing to vomiting the quinine is not retained, it is generally retained if given in whiskey. This also increases the rapidity with which quinine is absorbed. With regard to sub-tertian, especially cerebral cases, undoubtedly the best treatment is intra-muscular injections of Quin. Hydrochlor. Acid. There may be given up to a dose of 25 grains, and repeated in smaller doses, having regard to the temperature or mental symptoms of the case.

In the Salonica area there was at one time considerable excitement owing to the numerous cases of paralysis produced by careless intra-muscular injections. There is no need whatever for these risks. The deltoid may be a very convenient spot for intra-muscular injections, but undoubtedly the gluteal region is the easiest and safest spot for intra-muscular work.

When an instructor in intra-muscular injections I used to teach that the best site for injection was a spot at the junction of the outer and middle third of a line drawn between the anterior superior iliac spine and the top of the gluteal cleft.

Another objection that has been raised is the likelihood of abscesses due to quinine injections. I have seen several such but never where the injection has been made with aseptic precautions. The much debated question arises as to whether an aperient should be given at the outset when quinine is given by the month. Personally I think the best results are obtained by giving an initial dose of quinine and subsequently an aperient.

As regards blackwater fever the case must be judged on its merits as to whether quinine is given or withheld. So long as there is pyrexia over 100°, undoubtedly it is best to keep the patient under large intra-muscular doses of quinine given at prolonged intervals. The quinine should be withheld when the temperature drops. The patient should be kept on carbo-hydrates and glucose should be administered in large quantities.

As regards treatment of cerebral malaria by large doses of normal saline given intra-venously, in every case where I have seen this done the patient has died, as the enfeebled heart cannot pump against the extra fluid poured into the tissues and the lungs become water-logged.

For the anæmia and cachexia of malaria there is nothing better than intra-muscular injections of the Inject. Caco-dylate Co. prepared by the leading drug houses.

Finally, as regards prophylaxis, leading opinions differ very much on this. Personally I think that taking quinine as a prophylactic is futile, but no doubt many will disagree with me. There is one point of surgical interest as regards malaria. If a patient infected with malaria receives an injury to the bones, exostoses and new bone growth are liable to form. Generally speaking, operations on malarial subjects should be avoided if possible.

G. W. C. HOLLIST.

Otley,
Ipswich.

A University of London Union Society.

Dear Sir or Madam,

The students of the University of London have long felt the need of a centre for their corporate life. Our scattered colleges place us at a great disadvantage compared with students of the older Universities. It has therefore been determined to start a University of London Union Society on the lines of the Oxford and Cambridge Unions.

If a sufficient number of Undergraduates respond to this appeal, it is proposed to take a house in a central position, where Debates can be held at regular intervals, Reading and Writing Rooms be provided, and where teas and other light refreshments can be obtained, whilst in due course a suitable Library would be accumulated. These premises would thus constitute a Students' Club and common meeting ground exactly similar to the Unions at the older Universities. In connection with the holding of Debates we should add that this scheme has received the warm approval of the committee of the University of London Debating Society.

All matriculated students of the University, and all students taking full-time courses at the schools of the University would be eligible for membership, which would be by election. It is proposed that membership should be entirely individual, and no attempt should be made to interfere with or supplant any of the existing societies. The Officers of the Union should be entirely students, with the exception perhaps of one or two officials, such as the Treasurer, in whose case continuity over a period of years is desirable. The subscription should be as low as possible, and it is suggested that one or two guineas would be sufficient and that no entrance fee should be charged, at any rate for the first few years.

Some of us have had the opportunity of talking the subject over with the Vice-Chancellor, who

warmly supports the scheme and has promised to help us with his counsel and advice, but feels that if the scheme is to be a success it must be initiated, run, and controlled entirely by the undergraduates themselves.

If an adequate response is made to this notice we propose to call a meeting of those replying early in the Autumn term, to elect a provisional committee and officers, and further to discuss and forward the proposal. The University grows rapidly and is fast becoming of international importance. If the students are to play their full part in its future they must unite solidly to build a centre for their corporate activities. Should you be in sympathy with the project, and be willing to join the Union if formed, will you fill in the annexed form and send it to Mr. L. W. Harford, University College Hall, Queen's Walk, Ealing, or to one of the undersigned, any of whom will be pleased to explain the suggestions further if desired?

We are,

Yours very faithfully,

H. K. ARCHBOLD, Bedford College.
M. BOARDMAN, Royal Holloway College.
MARGARET URSULA BRADSHAW, Westfield College.
GWEN J. BROOKE, University College.
H. COWLE, London School of Medicine for Women.
A. T. DAVIS, London School of Economics.
W. J. DOWNE, New College.
JOAN ELLIOT, Westfield College.
B. I. EVANS, University College.
J. R. GAMMELL, University College.
R. GOODMAN, Charing Cross Hospital.
L. W. HARFORD, University College.
JOYCE HASLAM, King's College for Women.
MAY C. HERMES, Bedford College.
M. P. HODGSON, Royal Holloway College.
S. P. KIPPING, Berkbeck College.
H. G. MARTIN, East London College.
G. G. McKENZIE, London School of Economics.
OLIVE M. OSMASTON, King's College for Women.
E. M. SEXTON, St. Mary's Hospital.
M. E. SHAW, Guy's Hospital.
O. L. C. SIBLEY, Middlesex Hospital.
ELFRIDA SPENCER, Charing Cross Hospital.
E. J. STEELER, KING'S COLLEGE.
D. A. STEVENS, King's College.
C. H. C. TOUSSAINT, Guy's Hospital.
E. T. WRIGHT, St. Mary's Hospital.

N.B. During the first three weeks of the term over 300 prospective members have been obtained.

November, 1920.

A Case of Infantile Paralysis.

THE following case, to which the non-committal term of infantile paralysis may be most safely applied, seems worthy of record on three grounds.

Firstly, because of its bearing on the question whether even sporadic cases of infantile paralysis are not something more than a localised poliomyelitis, which is undoubtedly the case in many of the epidemic cases.

Secondly, as bearing on the question whether in such a case the disease is a single morbid entity due to some specific micro-organism as postulated by Flexner and Noguchi, or whether it is a modification of an antecedent infection by the specific virus of influenza, pertussis, morbilli or whatnot.

Thirdly, from a purely clinical point of view, the case illustrates the difficulty of diagnosis till late in such an illness.

To emphasise this third—the clinical—point of view, the case is given simply as the symptoms were noted day by day and recorded at the time. Undue space is given to symptoms that later proved immaterial, but that at the time, when one was groping for a diagnosis, appeared to open up paths which eventually proved only blind alleys.

Ronald F., aged 10 years, first seen at 8 p.m. on 20th October, 1920—with fever, delirium, and severe headache.

The following history was elicited.

14th October—(Six days previously) complained of headache at night.

15th October—Had a "bilious attack," was sick twice.

16th October—Much better.

17th October—"All right."

18th October—Very cold day, exposed, headache at night.

19th October—School in the morning, headache in the evening, feverish and restless all night.

20th October—Condition when first seen. A pale, weakly, nervous boy; poor family history. Had an attack of pneumonia two years ago. Complained of headache in the morning, getting worse during the day, chiefly frontal. Delirious towards evening. Constipated today, though hiterto bowels have been regular. Has had rigors during the day, also marked diplopia. When seen, answered rationally, but attention wanders. Bad frontal headache; restless; pulse at wrist cannot be counted owing to subsultus of tendons; counted with stethoscope 136; temperature 100°; tongue slightly furred; no enlargement of spleen; abdomen rather sunken and no pain or tenderness; no rash (by candle light). Pupils rather dilated, equal, reacting well to light; fundus oculi

normal. No history of otorrhœa or earache. No sore throat. No cough. Respiration sighing in character at times. No abnormal physical signs in heart or lungs. Very thirsty. Passing urine freely, loaded with urates. Feels sick; no retraction of head. Two other members of the family have had feverish attacks (? influenza) during the past few days. No albumen or sugar in urine.

21th October—Better in the morning; head clear; no recollection of incidents of last evening; no diplopia; movements of eyes and eyelids normal. When told to bend the chin on to the chest complains of pain in the shoulders. Kernig's sign absent. Knee-jerks sluggish; superficial reflexes plantar, cremasteric, and abdominal, lively and normal. Temperature 101·5°. Pulse 130. In the evening, after free action of bowels, temperature normal.

22nd October—In the morning, temperature normal. Pulse 136, weak. Headache less; tongue tremulous; complains of pain in nape of neck. In the evening, temperature 101°.

23rd October—Had a good night; temperature normal. Complains of vague pains "all over."

24th October—Had a bad night with pain in lower abdomen and legs. Temperature 100°. On examination of abdomen, it was found that neither testicle was in the scrotum, that on the right side forming a tender swelling about external abdominal ring. The left one cannot be found. The right testicle gives much pain on coughing. Much pain in both legs. Mother is quite sure that hitherto the child's testicles have been normally situated. Urine clear. On re-examination still normal. Belladonna fomentations applied to testis. In the evening, *statu quo.* Temperature 100·5°.

25th October—In the morning both testicles normally situated. Temperature 100·2°. Pulse 120. Complains chiefly of pain in right iliac fossa. No rigidity of abdominal walls; decided tenderness; doubtful sense of deep resistance on palpation; no pain referred to psoas and iliacus on flexing hip. Urine again examined; quite normal.

28th October—Was kept awake last night with cramps of right calf. Pyrexia has disappeared. Nothing detected in right iliac fossa. Temperature subnormal.

1st November—General improvement, but vague pains in right leg, chiefly at night.

6th November—General improvement. Has had no return of pyrexia; still very pale; bowels regular; appetite better; vague pains in legs, chiefly right, during past week, referred chiefly to hamstrings on extending knee. Full extension resisted. Cannot stand properly. Right knee-jerk found to be unobtainable even on re-inforcement. Left knee-jerk normal. Superficial reflexes all normal. Right achilles tendon jerk unobtainable. Left side present. No anæsthesia or paræsthesia to be detected. Tenderness of nerve trunks (sciatic and popliteal) doubtful.

8th November—*Statu quo.* Paresis of right leg continues, chiefly of flexors of knee. Right thigh more flabby. Right leg and foot colder than left. An attempt to determine the electrical re-action was found impossible without an anæsthetic.

28th November—A typical condition of infantile paralysis affecting chiefly the right hamstring muscles. Paresis, wasting, lowered temperature. No signs of any peripheral neuritis, nor of any lesion of upper neuron. Right knee-jerk very feeble on re-inforcement.

G. H. PENNELL.

The Cottage Hospital,
Edenbridge.

Reviews.

Tuberculosis: A Manual for Tuberculosis Nurses, Health Visitors, and other Workers. By G. Norman Meachen, M.D., etc. (The Scientific Press Ltd.)

The author of this little book on a big subject wisely sets out on the title page the classes of readers for whom it is intended. It might have been well if the duty of reviewing it had been entrusted to one of those for whose instruction it was written. She or he could have given expression to a personal sense of its usefulness. A fellow practitioner can, however, feel sympathy with the difficult task the writer has undertaken, and congratulate him on a very fair measure of success in surmounting it. It is perhaps inevitable that such a book should contain many scientific terms beyond the comprehension of non-medical readers, and should set out a good many facts that none but a medical man need know. Its perusal by any intelligent person could not, however, fail to increase his sympathy with the hard lot of the tuberculous patient, and with the strenuous task of his medical attendant. The author approaches the tuberculosis problem from a broad, humanitarian point of view, and recognises that the public has duties towards the unfortunate victims of this disease of much greater importance than safeguarding itself from the somewhat remote danger of infection.

The Industrial Clinic: A handbook dealing with Health in Work.

The reader who casually runs his eye through the Table of Contents of this volume will be struck by the new spirit that has entered into the relations between employer and employed. It is a far cry from the early days of the 19th century when little children were obliged to work in the mills for 12

and 14 hours a day, and when the philanthropist Robert Owen aroused and brought down upon himself hatred and contumely partly because he set up schools for the child workers in his mills at New Lanark, but chiefly because he believed in a 10-hour day for children.

History relates how Owen stood on the steps of his mill, and watched with a beneficent smile the little workers running about and calling, "We will have a 10 hours bill, that we will, that we will."

In the work before us we see the result of a long series of legislative measures, which started with the above mentioned 10 hours bill, and is still being added to. The casual reader will read such sub-headings as "The need for Industrial Medicine —A duty of Industry," and this phrase alone will indicate how the employer's duty to his workers is considered to be as important as, if not identical with, his duty to the State.

Thus "Industrial unrest is a psychological reaction to unfavourable environment: just as diminishing output is a sign of lack of physical energy. The call for health in industry has never been more urgent in the nation's history, for social and economic as well as for humanitarian reasons."

The volume has been edited with a view to helping Medical Officers and Welfare Workers in factories, and it is to be hoped that it will assist in bringing to an end many of the abuses which, during the War, arose out of the compulsory appointment of welfare-workers in certain cases, combined with the fact that very few people had been trained for this position requiring unlimited tact and discretion. Totally unsuitable persons, related to the owners, were placed in authority, and from their attitude of driving the workers, sprang the derisive sneer "Welfare equals Helfare."

Such chapters as that on the "Medical Examination of the Worker," by Dr. Deardon, will be found very useful to the medical man whose work has not hitherto led him to enter the factory gates; it contains information concerning the choice of suitable individuals for certain specialised forms of labour, so that physically, at least, the square peg may not be forced into the round hole.

The Home environment is also discussed, particularly in relation to those conditions which arise out of unhygienic surroundings, such as Scabies, Ringworm, verminous conditions and general lack of nutrition. The educative and preventive side of such work will react on the homes, and eventually on the children of the young persons who come under this care and supervision.

A section, useful in practice, and interesting from the scientific point of view is the one by Dr. H. M. Vernon, Investigator to the Industrial Fatigue Research Board. Over-fatigue is proved to act as a deterrent to out-put and it has been conclusively shewn that women who worked 66·2 hours a week gave a relative hourly output of 100 articles, but when this was reduced to 45·6 hours a week 158 articles per hour were produced.

Prof. Leonard Hill contributes an admirable chapter on Food Values in Relation to Occupation, shewing the necessary amount of the basic food substances required to produce the energy for certain forms of work.

There is a very interesting chapter on the Industrial Employment of Women, and anybody who has ever worked among women of the factory class will realise the vast amount of good it is possible to achieve.

The writer, Dr. Adamson, emphasises the fact that the Medical Officer should be a woman, and indeed the relief the woman workers may obtain in minor disabling conditions, particularly those consequent on childbirth, may be as invaluable as it is incalculable. The writer wisely emphasises the need for privacy in these consultations, and particularly stresses the importance of keeping the records under the care of the Medical Officer herself, so that they may not be subject to inspection by the factory administrator, who has to carry out the doctor's recommendations, or any other inquisitive persons, a line which seems far removed from that taken by the Ministry of Health in relation to its Panel patients.

The book is well illustrated with photographs of various pieces of apparatus, and of workers in special uniforms, and we can strongly recommend it to the general practitioner in working-class neighbourhoods, to welfare and social workers, and especially to doctors who are actually working in the factories, or who are engaged in Preventive Medicine.

Specialities.

Vittel Natural Mineral Water.

Vittel takes its name from a small town in the department of the Vosges, situated 1,150 feet above sea level, whence from the mountains above, flow two streams called "La Grande Source" (The Great Spring), and "La Source Salée" (The Salime Spring).

This little town has been established as a Spa, with a handsome Pump Room, and is visited by many sufferers annually for the curative properties of its Waters.

From analysis, these Waters are eminently suited to people suffering from Gout, Neurasthenia, Arterio-sclerosis, Oxalæmia, Obesity, Arthritism, etc.

The Vittel Natural Mineral Water Co., are supplying these Waters direct from the Springs at a very moderate price in conveniently sized bottles.

To those, therefore, who are unable to avail themselves of a cure at this Spa, The Vittel Water Co., affords an excellent opportunity for treatment at home.

The Vittel Natural Mineral Water Co., will be pleased to supply a sample bottle to any member of the Medical Profession.

Burrows' Table Waters.

These waters may justly lay claim to the front rank amongst the many offered to-day, to the public.

St. Ann's Well, situated in the Malvern Hills, has long been famous for the purity of its water, being practically free from any organic matter.

Messrs. W. and J. Burrow are sole lessees of The Springs, Malvern, and are supplying these Natural Waters in handsome and conveniently sized bottles, to anyone in the United Kingdom, at a moderate price, carriage paid.

Those, therefore, desiring a thoroughly good health-giving table water, may feel assured in availing themselves of the Alpha Brand Malvern Water.

Veda Bread.

By a scientific method in the treatment of Wheat and Oats, the Veda Bread Co. are manufacturing both Bread and Oatmeal by a process in which the insoluble carbohydrate has been reduced to a minimum, and the soluble carbohydrate rendered easy of digestion.

Both these food products will be found specially suited to Dyspeptics and persons suffering from weak digestion.

They are prepared from the finest grain procurable and have the advantage over similar grain foods, as the nutritive parts are entirely and readily absorbed.

The Flour from which this Bread is made is also supplied by the Company if desired.

Pass List.

University of Cambridge.

ACT FOR DEGREE OF M.D.

R. J. Hearn.

Interesting Cases in the Medical Wards

Dr. Hurst and Dr. Hunt—

Addison 30 Addison's disease.
" 31 Acute ascending myelitis.
" 34 ? gumma of liver.

Football.

GUY'S v. OLD BLUES.

The Old Blues suffered a heavy reverse at Honor Oak Park on Saturday, November 27th, by 7 goals 2 tries (41 points) to 1 try (3 points). This was the total against them. How did it all happen? C. Marais, J. Krige, H. Graham-Davies, W. Olivier, R. F. H. Duncan, F. J. Biddle were not playing. Those that composed the XV., however, exhibited remarkable team work and general combination. The leadership of W. D. Doherty was another tremendous asset. His enthusiastic play has seldom been followed with such zest by his pack. On Saturday, November 27th, they were all on their toes, so to speak, and all deserve special mention, but the others will forgive me if I mention the play of A. H. Shelswell and F. W. Crook. Shelswell's day out it was. Crook, when he gets a bit more fit, will be very difficult to overlook. Fast and strong, he is a typical example of a Hospital forward. Play had been in progress about 10 minutes when A. H. Van Zyl signalised his re-appearance in the team, after a painful illness, by scoring a try wide out. The Hospital men now had to defend, the Old Blues footwork was good, but surely when up against a weightier pack it is asking for trouble to play only seven forwards. These seven dribbled well while they lasted, and H. Van Heerden showed us some delightful kicking and saving. I didn't notice his left foot in action much; perhaps practice will improve this, but his display was very fine all the same. During this strenuous period of Old Blues attacking, L. K. Watson went down to the ball splendidly, but one defender does not dive at the oncoming rush and sit on the leather or pick it from the feet of the dribblers, he sticks out the back of his foot and hopes for the best. R. A. Pennington got a fine try just about this time, he ran well, sold a cheap dummy, I couldn't see

quite, but about 3 Guy's men bought it, and got well round. Before half-time Albertyn and Bekker got tries. Albertyn's was a clean cut through. Bekker dished the defence and walked over to place the ball gracefully behind the line. With magnificent shots E. E. Neser goaled all 3 tries. We crossed leading by 15 points to 3.

The second half saw tries scored in quick succession. Crook got the first, Shelswell the next, this Reitz helped with, from midfield though Shelswell did it himself and ran well. Steyn came with the next, he played a remarkably good game, putting much more "buck" into it. Watson got the next try. One wishes he would put on weight. Albertyn sold a dummy pass to many Old Blues and passed over to the posts. Then Van Schalkwijk did the same. Never did one see so many scores registered simply through failure to go for the man with the ball. Van Schalkwijk converted 4 of these tries. The wings, Daneel and Williams, have not quite pace enough, but are good sound triers. One was glad to see more determination in attack and less of everlasting kicking. The Old Blues were good losers they kept at it till the end and neither groused nor talked; they proved they could lose with the same cheery sportsmanship that the writer has often seen them win with.

Guy's Team:—H. Van Heerden, H. K. Williams, C. L. Steyn, P. K. Albertyn, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, E. E. Neser, A. H. Van Zyl, A. H. Shelswell, R. Macintosh, L. K. Watson, F. W. Crook.

GUY'S "B" v. HONG KONG AND SHANGHAI BANK.

This match was played on Saturday, November, 27th. The "B" team welcome the return of Currie who, though elected Captain some time ago, has been unable to turn out until now. The team's thanks are due to Seward for much good work as deputy Captain.

The above game was played under very pleasant circumstances at New Beckenham. Van der Post toured London before arriving there after half-time, so that Guy's played 14 men throughout. It was chiefly a forward game, and the seven Guy's men in the scrum had to work hard but held their own. The "threes" made good use of the chances they got and scored two very creditable tries, the halves and three of the threequarters handling the wet ball each time. Seward converted the first try but struck the crossbar with his second goal-kick.

Guy's were penalised twice in front of goal but the Bank's kicking was "rotten." The second penalty went very wide, and following it up the Bank scored their second try. Currie and his team exchanged apologies for this.

Daneel was very sound at full back. Aung was almost brilliant at times. Hibbins achieved distinction and a black eye.

The Bank ladies, cheering vigorously on the touch line lightened the labours of a very hard game. The score was Guy's, 1 goal and 1 try (8 points, Bank, 2 tries (6 points).

Guy's Team.—Daneel, Young, Walters, Van der Post, Newbery, Aung, Seward, Currie, James, Ive, Estment, Cross, Orsmond, Strong, Hibbins.

GUY'S "A" v. R.N.C.

Our "A" XV. met and defeated the Royal Naval College, Greenwich, at Honor Oak Park, on Wednesday, 1st December, 1 goal and 4 tries (17 points), to 2 goals (10 points). Guy's went all-out to defeat the Kent Cup holders, who defeated us twice last year on their own ground. Consequently the game was a very keen, but neat one. Very shortly after the start they led by 5 points, but soon after this, Taylor started the scoring for Guy's, by a good try which was converted. Further tries were added by Wynberg, James and Taylor, which were unconverted. Wynberg shaped fairly at centre and Meacock very cleverly put his backs on the move time and again and thus gave his side many splendid opportunities.

Guy's Team.—Jacobz, James, L. A. Wynberg, E. E. Neser, Williams, S. P. Meacock, Nurick, Watson, Taylor, Crook, Harvey, Helder, Cooks, Bradfield, Mackenzie.

GUY'S v. OLD CHOLMELIANS.

This match was played on Wednesday, October 20th. Owing to the United Hospitals v. Cambridge match taking place on the same day, Guy's turned out rather a weak team to play Old Cholmelians.

Guy's started well, and after 20 minutes mid-field play a nice combined effort resulted in Payne scoring for the Hospital. From the centre Guy's again took the initiative and Van Geuns put in a fine shot which the goal-keeper had to divert to a corner. This, however, was unsuccessful, and the play was carried down to the other end, where the visitors took up the offensive and it was not long before the Hospital had to concede a corner, from which the Old Cholmelians scored, Hardy having no chance. From this point the game went on in ding-dong fashion until half-time.

From the re-start the Old Cholmelians monopolised the play and it was not long before Hardy was tested by a hot shot making a brilliant save, but being ultimately beaten. This put the visitors one goal ahead. This spurred Guy's and a nice effort on

the right wing resulted in Nicholls scoring with a shot that gave the goal-keeper no chance. After this effort Guy's petered out, except for one or two spasmodic efforts. The visitors scored another goal and kept their lead till the whistle blew.

The most outstanding man in the match was Hardy, who saved some fine shots and cleared well. The backs, the best of whom was Riddolls, were not quite sure, perhaps owing to the slippery state of the ball. The half-backs played well, Pengelly being the best, but the wing men must remember to mark the outside forwards. The forwards were good, at times working well together, Van Geuns, Nicholls and Payne being the best. Result: Guy's 2, Old Cholmelians 3.

Guy's Team—Hardy, Sennitt, Riddolls, Corry, Pengelly (captain), Lipschitz, Van Geuns, Nicholls, Williams, Payne and Ward.

GUY'S HOSPITAL v. OLD GRAMMARIANS.

(*2nd Qualifying Round A.F.A. Cup.*)

Played at Honor Oak Park on Saturday, November 13th. Guy's lost the toss and were at once called upon to defend. At the end of ten minutes' play Old Grammarians headed in from a corner, Hardy being given no chance. From the restart our forwards began to press, but their play lacked finish at this point, as it did for most part of the game. Trott had bad luck with a shot which passed just outside the goal post. Shortly afterwards, following good play by our half-backs, two centres from the respective wings failed to materialise owing to lack of initiative on the part of the inside forwards. For the remainder of this half play was confined to the vicinity of our oponents' goal; their backs, however, kicked and tackled splendidly, and as a result their goal-keeper was seldom called upon to field the ball. Half-time arrived with the score 1—0 against us.

During the first twenty minutes of the second half play was very even, and on many occasions Guy's looked like equalising, especially when a centre from Van Geuns rolled across the goal-mouth out of play. Following good play on their left wing the Old Grammarians scored again with a fast ground shot in the corner, which Hardy just failed to hold. Guy's were now awarded a penalty following a foul on Morgan. Couch took the kick and failed to score. Just before time our opponents scored again. Final Score: Guy's 0; Old Grammarians 3.

The defence, both individually and as a whole, played splendidly. Van Geuns was the best of the forwards.

Guy's Team.—Hardy, Wakeford, Riddolls, Pengelly, O'Meara, Couch, Van Geuns, Williams, Nicholls, Trott and Morgan.

GUY'S HOSPITAL v. OXFORD UNIVERSITY CENTAURS.

Played at Honor Oak Park on Wednesday, 1st December. For the first ten minutes of this match Guy's were two forwards short and their defeat can, to a certain extent be attributed to this cause, since during that period a heavy amount of work was thrown on the defence. The Centaurs pressed at the outset and at the end of about five minutes play scored with a grand shot. Guy's now had ten men and the pressure was somewhat relieved, play being carried to the vicinity of the Centaurs goal on two or three occasions. However, shortly afterwards the Centaurs scored again, after a sustained bombardment. The forwards were now at full strength again showed splendid form, both individually and as a line. Just before half-time Williams scored for the Hospital. Half-time score: 1—2.

During the second half play was very fast and even, both sides pressing in turn. There was, however, no score till fifteen minutes before time, when the Centaurs goal-keeper fisted out a hot shot from Couch for Williams to score easily. The game was now very keen, both teams trying hard to obtain the winning goal. Following a break-away on their right wing the Centaurs scored.

Guy's Team.—Hardy, Wakeford, Riddolls, Corry, O'Meara, Couch, Van Geuns, Nichols, J. S. Williams, Trott and Morgan.

GUY'S HOSPITAL v. OLD ALDENHAMIANS.

Played at Honor Oak Park, on Saturday, December 4th. A gale of wind blowing across the ground made accurate play an impossibility, confining it as it did to one side of the field. Nicholls and Trott both scored for the Hospital in the first half. The Old Aldenhamians also scored following a corner.

In the second half both teams scored twice. The scorers for the Hospital being Williams and Van Geuns.

Guy's Team.—Hardy, Wakeford, Riddolls, Trafford, O'Meara, Couch, Van Geuns, Nichols, Williams, Trott and Morgan.

Hockey.

GUY'S v. WAR OFFICE.

Guy's were at home to the War Office on Saturday, November 27th, and a capital game resulted in a draw, three goals being scored by each side.

The War Office were early settling down to their game and led the pace for the first quarter of an hour or so, scoring twice from good shots by Clements. Guy's, who had previously been very

scrappy, now got together, and the game—which was very fast considering the weather conditions—settled into a hard give and take tussle. Hunt scored for Guy's just before half-time, which was reached with the score 2—1 in favour of our opponents.

In the second half our team were able to stand the pace better than the War Office and had the best of the play, two goals, scored by Graham-Bonnalie, giving us the lead. Rawson, however, soon equalised for the War Office and although Guy's were continually in the War Office "25" for the last few minutes of the game ,they were unable to score again, and the game ended, as stated, in a draw, 3 all.

Guy's Team.—C. T. V. Baugh, C. G. Bowen, W. F. Hurdle, H. Slater, J. R. A. Moore, S. C. Olver, W. S. Hunt, J. V. Schollum, F. E. Graham-Bonnalie, B. M. Tonkin, L. E. Owen.

Other Matches—

Nov. 27th—Guy's II. v. Broxbourne I., lost 2—3.

Dec. 1st—Guy's A. v. Westminster College I., lost 1—4

Dec. 4th—Guy's II. v. Birkbeck College I., won 6—5.

Coming fixtures—

Dec. 11th—v. Dulwich (1st XI. Home; 2nd XI. Away).

Dec. 18th—v. Royal Observatory (1st XI. Home; 2nd XI. Away).

Fives.

On Wednesday, 1st December, a match was played against the London Hospital.

Guy's were represented by Messrs. R. S. Chambers, T. A. Shaw, W. R. Spurrell and J. D. S. Thomas.

The match resulted in a draw, each team winning four games.

Review.

Minor Surgery and Bandaging (Heath, Pollard, Davies). By Gwynne Williams, M.S., F.R.C.S., Assistant Surgeon, University College Hospital. 17th edition, 1920, pp. 447. (Messrs. J. & A. Churchill.) Price 10s. 6d. net.

Little comment is necessary in introducing the latest edition of this book to our readers; the fact that it has reached the 17th edition indicates that it has come to be regarded as one of the best authorities on the subject. To house surgeons and junior medical men, for whom it is written primarily, it has proved itself invaluable, owing to the abundance of practical hints in the treatment of the minor conditions in surgery.

We should like to congratulate the author on the thorough manner in which the book has been revised, and brought up to date by the inclusion of those parts of war surgery which will prove useful in the future, in civil practice.

Papers by Guy's Men.

C. H. Bubb, O.B.E., L.R.C.P., M.R.C.S., L.D.S., Report of the Research Committee, 1920, with some Suggestions and Queries as to the Source and Role of Periapical Infections.—*British Dental Journal*, XLI., p. 1097.

R. P. Rowlands, M.S., (1) Hydronephrosis due to Abnormal Renal Vessels kinking the Ureter; (2) Partial Gastrectomy for Simple Ulcer; (3) Hour-glass Stomach with Pyloric Stenosis treated by Gastro-jejunostomy, followed by Gastro-gastrostomy; (4) Carcinoma of Stomach; Partial Gastrectomy.—Proc. Roy. Soc. Med., XIV., Clinical Section, p. 6—9.

Arthur J. McNair, M.B., Placenta Prævia, with Vesa Prævia; Cæsarean Section.—*Ibid.* Sec. of Obstretrics, p. 195.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Births.

FOSTER-SMITH.—On October 8th, 1920, at Miri, Sarawak, the wife of G. T. Foster-Smith, M.B., B.S.Lon., of a daughter.

SOOTHILL.—On November 28th, at 40, Dorchester Road, Weymouth, Kathleen Helena, wife of V. F. Soothill, M.A., M.D., D.P.H., of a daughter.

THOMSON.—On October 11th, at B. Section, 82nd General Hospital, Constantinople, the wife of Captain G. Y. Thomson, I.M.S., of a son.

Death.

GREENWOOD.—On Sunday, 24th October, at 8 Park Road, Kingston, Surrey, Mr. J. H. Greenwood, L.D.S., R.C.S.Eng.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Photo by G. A. Walker, Biology Dept., Guy's Hospital.

CHRISTMAS GREETINGS FROM THOMAS GUY.

Passim.

IF the Christmas posts are not unduly delayed, we hope that the majority of Guy's men will receive this copy of the GAZETTE on Christmas Day, and with it our hearty good wishes for their happiness. Not a few, no doubt, will be thinking of many a happy Christmas spent within the walls of the Hospital and the photograph above, depicting the lonely figure of our founder gazing out upon a scene traditional but fortunately not typical of Christmas-tide, will conjure up a crowd of happy memories—of niggers and ward concerts, and the countless festivities that go to make up a "Hospital Christmas."

We were talking the other day to an old Guy's man, who told us that he was one of the niggers as long ago as 1868. In those days they *were* niggers—so far as burnt cork and high collars could make them. Nowadays the niggers, if less black, are perhaps a touch more picturesque and certainly more comfortable.

Face-blacking is a messy business. But apparently the Ethiopian can change his skin We still have our Massa Johnson; and even if he and his hard-working band have white faces, we enjoy them just as much as ever. We laugh at their jests and applaud their songs, and the patients thoroughly enjoy it, which, after all, is the main thing.

One Christmas at Guy's is very like another. Faces change, men come and go, the very walls are destroyed and built afresh, but Christmas Day remains the same in spite of all. To a resident of fifty years ago it is probably about the only recognisable feature of the Hospital. To him, if he returns, it must appear that everything has changed. The Medical School Buildings, the Nurses' Home, the Front Surgery, much of the Out-Patient Department, and the Salomon's Centre—all these are new. Even as we write, a large new wing stands nearly completed in the Park, and the last remains of Clinical are almost pathetic in their loneliness. But let him come on Christmas Day and then he will see the Hospital in the guise of olden days. He will find the same irrepressible spirits, the same air of festivity, and, perchance, many of the same old jokes. Fifty years hence, if any of us live so long, we may return to find a new Hospital, perhaps—who knows?—under the control of the State. The Eye Wards may have windows, the lift in Hunt's House may possibly no longer be monopolised by the Department on the top floor, and conceivably the food in the College may be eatable. But if we come on Christmas Day we may be sure to find the same old niggers and the same old big drum, the same assortment of pet children in the wards, and, if we venture to the Out-Patient Department in the afternoon, we shall be compelled to admit that the Boro' child has altered little in his capacity for food and noise. So may it always be.

BY the time these lines appear the Superintendent will have announced the fact that the New Year's Eve bonfire is to be no more. This will doubtless be a profound disappointment to many, but we earnestly hope and believe that the necessity for its abolition will be realised and that the Governors will be loyally supported in making a decision to which they have been driven rather reluctantly by force of circumstances. There has for a long time been a number of distinguished members of the hospital who have considered the bonfire a mistake. In the first place it is not an ancient tradition, having only been introduced within the last twenty years. Secondly, a fire of the customary magnitude is not without its dangers in so confined a space as the Front Quadrangle, especially when a high wind is blowing. It will also be remembered that the upper rooms are all inhabited by nurses, and these rooms would be the first to suffer if an accident did occur. Further, it must be admitted that Guy's is a hospital, and even on New Year's Eve there are many patients for whom a midnight conflagration with its inevitable accompaniment of noise and discord is not the most appropriate treatment. But in spite of all these considerations, it is doubtful whether the matter would ever have come to a head had it not been for the company who are responsible for the Hospital's Fire Insurance Policy. They, not unreasonably, claim that risks from bonfires are not included in their policy, and a question of expediency is thus converted into one of urgent necessity. These facts must be evident to all and we appeal confidently to the present generation of Guy's men to forego indulgence in this rite which is neither essential to the occasion nor the traditional method by which it should be celebrated.

DR. LISTER'S letter on page 460, dealing with the activities of the University of London

Athletic Union, raises questions of vital importance to hospital athletics generally, and indeed to all members of the University. We are glad that the University is alive to the necessity of corporate life and corporate games, for only by the organisation of these on a sure footing can a University give all that it owes to its alumni. The difficulties under which the University of London has laboured in the past owing to its widely scattered constituent colleges has been apparent ever since its foundation. In many ways it has been more a *di*versity than a *uni*versity. But in spite of these inherent difficulties, it is clear that the University is resolved not to allow Oxford and Cambridge a monopoly of that corporate existence for which their unique topography renders them peculiarly suitable.

It is good to hear that a University Boat Club is in process of formation. In one respect London should have the advantage over the Oxford and Cambridge Boat Clubs in having the use of water unimpeded by locks and sufficiently broad to enable a number of boats to race abreast. Whether the London Boat will ever be able to hold its own against those of Oxford or Cambridge is another question. We doubt it. The older Universities get the pick of the School oarsmen, and upon these any University must largely depend if it proposes to produce a first-class crew.

In our last issue we raised the question of the composition of representative University sides and questioned whether it would be wise or politic for these to include members of Colleges of the University who were not matriculated undergraduates. Oxford and Cambridge provide no analogy, for the number of men studying under the auspices of the Universities but not actually matriculated is almost negligible. In London the non-matriculated are very numerous—probably a majority of the total number of students. Dr. Lister does not suggest what policy the University would adopt towards these men, but it seems clear that in competing with other Universities the same rule should apply to all, If this were not so London would hold an advantage that might justly be considered unfair.

MR. FAGGE'S clinical lecture on the Value of Blood Examination in Surgery stimulates us to voice a grievance which is continually being brought forward by surgical ward clerks and dressers. Mr. Fagge shows that blood examination is of great value in many surgical conditions, but there is no apparatus in the surgical wards of the Hospital for even such simple investigations as blood counts and hæmoglobin estimation. The ward clerk or dresser who undertakes to do a blood count in the surgical wards has to borrow a hæmatocytometer from an unwilling sister on the medical side. And even in the medical wards the apparatus is often missing or deficient. Surely a few hæmatocytometers and the necessary fluids might be provided on the surgical side.

Pass List.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES.

I. M. Benjamin.
L. Davies.
J. Evans.
T. M. Fripp.
J. C. Hewetson.
E. F. Hewlett.
R. M. Jones.
H. Lewis.
C. E. H. Moykopf.
T. C. Pain.
Max Rubenstein.
F. W. Schofield.
Eric Wornum.

Change of Address.

H. L. Ide, L.D.S., "Blankney," 8, Park Road, Kingston Hill, Kingston-on-Thames.

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The Value of Blood Examinations in Surgery.

CLINICAL LECTURE BY C. H. FAGGE, F.R.C.S.

GENTLEMEN,—The general examination of the blood is of clinical value in surgery, because by it we can detect the presence of parasites, and many pathogenic bacteria. These, of course, may be detected by direct examination, or by culture, but, as a practical point, we have to bear in mind that when blood is sent for culture it should always be taken during a period of pyrexia or during a rigor, otherwise a negative result will usually be reported. Further, we send blood for estimation of the urea in it in cases in which we suspect the kidney function is not normal; because we know that if the amount of urea in the blood is increased three times above the normal of ·3 grm. per 1,000 c.c., the patient is not a sound surgical risk. The estimation of urea in the blood and of the resulting degree of renal deficiency is usually in expert hands, and it is not a thing that we can undertake in the wards.

It was definitely proved by Wright that the defect in hæmophilics is an increase of the coagulation time. Whatever may be the factor at fault, whether it is that the pro-thrombin, which presumably is derived from leucocytes, is deficient, and this is the cause of the increased coagulation time as Addis affirms, or whether there is some other factor such as an increase of anti-coagulation bodies, *e.g.*, anti-thrombin, we know that the deficiency is not due to any anatomical abnormality in the walls of the blood vessels in these patients. We also know that we can decrease their coagulation time very considerably by giving a small dose of normal blood, and it has been proved that the same result can be brought about by giving them washed leucocytes, which suggests that these supply the deficient coagulant. If they are suffering from a hæmorrhage this can be overcome by these means. The normal coagulation time when measured by Wright's method is from three to six minutes, but in a hæmophilic it may be increased to anything from 15 minutes to an hour.

We now come to the consideration of red blood corpuscles, normally 5,000,000 per cubic millimetre. A reduction in the number of these corpuscles takes place in any condition of anæmia, which in surgical work is most commonly due to hæmorrhage. The colour index which is the percentage of hæmoglobin divided by the percentage of red blood corpuscles, is of a certain amount of value in surgery. Whenever the red blood corpuscles are reduced, the hæmoglobin is reduced, but these two are not reduced equally. If blood is examined immediately after a severe hæmorrhage the colour index is perfectly normal, but after a short time as the volume of the blood is being replaced by serum from the tissues, it becomes more diluted; both corpuscles and hæmoglobin are reduced, the pigment more than the cells, so the colour index falls, and as the corpuscles are much more quickly replaced than the hæmoglobin, the colour index continues to fall for some days.

As a practical point you may remember that if the hæmoglobin is reduced 1 per cent. it takes a day to recover—the blood recovers its hæmoglobin at the rate of 1 per cent. per day. I suppose it was on this basis that when walking wounded were used to give blood they were allowed three weeks off duty to enable them to recover their hæmoglobin. I doubt whether their hæmoglobin was ever reduced more than 10 per cent., though their colour index might have been considerably lower. I did not see any in which there was a perceptible anæmia.

It is clear that a gradual loss of blood has a less dangerous influence upon the hæmoglobin ratio than a rapid one; thus a patient will survive a greater gradual loss than when it occurs rapidly. We have as yet no definite knowledge which enables us to know how much blood can be lost with safety, but taking the percentage of hæmoglobin as our guide, a rapid reduction to 50 per cent. will probably be fatal, whereas a much greater gradual fall is not a bar to recovery; as a general rule we must regard a reduction of hæmoglobin to 30 or 40 per cent., even when it has taken place gradually, as a very serious operative risk.

Here is a blood chart of a patient in whom this point had to be taken into consideration; he was a man of 45 who became quite anæmic from continued melæna; from his history, examination of his fæces, bismuth X-rays and a test meal it was concluded that the cause of this loss of blood was a chronic duodenal

ulcer. Before operating on this patient a blood-count was done which showed that he had 4,500,000 red cells and that his hæmoglobin was reduced to 80 per cent., from which a colour index of ·9 was adduced. The man, however, looked more anæmic than a ·9 colour index, and this estimation helped us to realise that he would safely undergo operative interference.

In pernicious anæmia the colour index is high; there is a marked anæmia with a high colour index and variations of the red cells (poikilocytosis). In secondary anæmia the colour index is low, as it is in chlorosis; it must be remembered that it is important to differentiate pernicious anæmia from some types of abdominal malignancy. Those of you with some experience of malignancy of the stomach or colon will know that when one's predilections are medical, such cases may be wrongly labelled as pernicious anæmia, whereas the surgeon is prone to operate on cases of pernicious anæmia, regarding them in mistake as cancer of the stomach or colon.

The high colour index in pernicious anæmia should readily distinguish it from the secondary anæmia of malignancy with its low colour index. In malignancy occurs the second typical example of a secondary anæmia—a diminution of the red cells, a low colour index, and a whitish-grey or yellow colour of the patient, particularly when some degree of cachexia has set in. In these cases one often finds some degree of sepsis, and the anæmia of sepsis is superimposed on that of malignancy.

I think we do not always sufficiently realise the diagnostic value of a high degree of anæmia in patients suffering from sepsis. This usually means, of course, that a hæmolytic streptococcus is the organism present. We realise quite readily that hæmorrhage and malignancy produce anæmia and the most important other surgical condition that produces anæmia is an acute infective process.

In Banti's disease (splenic anæmia) a variation of the red cells occurs in that some are nucleated; the normal red cells in this type of secondary anæmia are peculiarly friable and their resistance to hæmolysers is very much reduced. We may recall that the complete picture of splenic anæmia is an anæmia with a low colour index, without marked change in the leucocytes, but with friability and diminished resistance to hæmolysers of the red blood cells; also a large spleen, sometimes with a tendency to hæmorrhages and later to jaundice. These conditions, taken together, will usually enable us to arrive at a diagnosis of splenic anæmia and afford a clear indication for splenectomy which will often lead, if not to a cure, at least to an arrest of the disease.

When the total leucocytes exceed 7,000 per c.m. we speak of a leucocytosis, and when it is less than 5,000 we call the condition leucopenia. For us as surgeons the most important instance of leucocytosis is the reaction that takes place in inflammation. Just as it is difficult to know how far inflammation must be regarded as a protective process and when it becomes pathological, so we do not seem to know how far the reaction of the cells of the blood, or the tissue cells, in inflammation is beneficial or the reverse. We must look upon leucocytosis, up to about 12,000 c.m., as a normal protective mechanism against bacterial invasion. When any part of the body is invaded by bacteria, toxins pass into the blood stream from the parts where the infection is taking place, and excite the bone marrow, in which, of course, they circulate, to produce more leucocytes; they also attract by chemiotaxis the leucocytes into the blood stream. This is a natural protection, whereby an organism employs its white blood cells for the battle against bacteria. We know perfectly well that when in face of a sudden acute attack the organism does not so employ its white blood cells that the prognosis is extremely bad. If in the presence of an acute infection, such as septic peritonitis, no leucocytosis occurs, the patient is not putting up a fight against the infection and will die. On the other hand, of course, a leucocytosis of, say, 30,000 or 50,000, indicates, as a general rule, in the presence of an acute infection that pus is forming, and it is in this connection that leucocytosis is most generally regarded as a surgical indication. I think the converse is equally important and that we do not pay enough attention to it. Within limits we should regard leucocytosis as a protection to the individual; when it is present it is an important factor in good prognosis, and when it is absent the prognostic indication is bad.

When speaking of the value of leucocytosis as a surgical indication it must be carefully pointed out that it is rather an index of the process of suppuration than that an abscess has actually formed; this is particularly true in

chronic cases, and if we act too rapidly on this indigation we may be disappointed by not finding a collection of pus.

Many of the inflammatory conditions for which surgical treatment is undertaken are accompanied by a mild degree of leucocytosis; thus appendicitis, which is, perhaps, the condition in which the presence of pus is called in question most often, will, even when the acute inflammatory stage has not been passed, give rise to a leucocyte count of some 10,000—15,000, but should the count run up to 20,000, 30,000 or even 40,000, then we have a very good suspicion that suppuration has taken place.

We have to remember that several other, non-surgical, conditions produce it. Perhaps the most misleading from a surgical point of view is the leucocytosis which occurs in pneumonia. We often want to know whether a patient, who is doing badly after an abdominal operation, has some complication in the chest or something in the abdomen. Erysipelas, pneumonia, and scarlet fever will all produce leucocytosis as contrasted with a diminution in leucocytes which occurs in influenza, malaria, and in tuberculosis, which are about the only three diseases which are likely to give rise to confusion with acute inflammation. One exception which must be borne in mind in regarding leucocytosis as an indication of suppuration is that it is not at all marked in a suppurative inflammation of any of the mucous membranes. This is explained by the fact that the cause of leucocytosis is an absorption of the toxins into the blood stream which there attract the leucocytes; this absorption of toxins into the blood stream does not take place so readily with suppuration on mucous surfaces and so leucocytosis does not occur.

So far when speaking of inflammatory leucocytosis, we have dealt only with the total count; while in inflammation all varieties of white cells are increased, the greatest increase is of the polymorphonuclears which in the presence of pus may rise from the normal of 72 per cent. up to 80 or 90 per cent.

Passing on now to other variations in the white count in different diseases, we find the lymphocytes relatively increased in typhoid and tuberculosis above the normal of 23 per cent., although the total white count is normal; it is in lymphatic leucæmia that an appreciation of the excess of lymphocytes becomes of importance surgically; here with a total count of possibly 100,000, 90 per cent. may be small lymphocytes.

In any patient with multiple enlargement of the lymphatic glands, lymphatic leucæmia must be borne in mind; a blood count may be the thing which suggests the correct diagnosis when tuberculosis, Hodgkin's disease, lympho-sarcoma or lymphatic leucæmia are all possibilities, for only in the last named is there a leucocytosis, and the excess of lymphocytes at once attracts attention in the differential count.

Eosinophiles form, in ordinary conditions, only 2 per cent. of the total white cells, and they are increased in certain diseases, the most important of which are parasitic diseases, such as worms, and hydatids. There is a slight eosinophilia in gonorrhœa. The diagnostic value of eosinophilia, however, is diminished by the fact that it also occurs under certain physiological conditions of food and exercise.

In spleno-medullary leucæmia the characteristic blood picture is a marked leucocytosis, reaching, perhaps, 500,000 per c.m.m., of which 40 to 50 per cent. are myelocytes, large multi-nucleated white cells which are not found in normal blood. They, of course, come from the bone marrow, and in this disease the marrow is extremely active. Now every surgeon wants to bear in mind and understand spleno-medullary leucæmia, because it sometimes gets us into difficulties. Some of you may know a man in Cornelius whose case has been of great diagnostic difficulty, and finally he was found to have spleno-medullary leucæmia. We had in Lazarus about six months ago a man who was sent to me as a case of enlarged spleen. I saw and examined him and did not agree. There was a variable swelling under the left ribs which was so tender that I could not help thinking that it was some inflammatory mass in connection with the colon. As I opened the abdomen I noticed that the blood was very thin and pale; this I attributed to a certain amount of septic anæmia or possibly malignancy. The tumour that one could feel was an enlarged spleen over which there was a considerable amount of peri-splenitis. We closed the abdomen, and he began to ooze from the wound; his life was only saved by Mr. Joffe giving him 10 c.c. of horse serum under the skin and a grain of calcium chloride into the buttock. We found that he had a high leucocytosis and many myelocytes.

Now it is an interesting coincidence that we stand on the very spot on which, in 1865, Mr. Thomas Bryant first purposefully removed the spleen in London. In 1866 the procedure was repeated; both were cases of splenic leucæmia and both proved fatal. You will find that Spencer Wells removed one about the same time on the supposition that it was an ovarian cyst. It was not until quite recently that it has been possible to remove the spleen with safety in leucæmia, but there seems to be fair evidence that if the leucocytosis is reduced primarily by exposure to radium, then splenectomy can be undertaken in this disease. I do not wish to pursue the subject from the point of view of whether splenectomy should or should not be done for lymphatic leucæmia; I was only trying to help you to see how I made a mistake in operating upon a patient with leucæmia merely because one was too blind or careless to remember to have a blood count before doing a laparotomy, although it had been suggested that the patient had a large spleen. It is very good for me to confess these things, but I am afraid that one never learns much from other people's mistakes, but has to make them oneself, in surgery no less than in ordinary life.

I am not going to say much about serum reactions, because they are rather outside my subject. The serum reaction (Widal) in typhoid indicates a degree of immunity acquired by former infection; it is well to bear the broad pathological principle in mind, for the use in other diseases of such specific agglutination might be useful in helping to solve what are at present hidden truths. Then the complement fixation test in syphilis, by which we acquire the knowledge that the patient has had syphilis, is of great diagnostic value. We have to bear in mind that a patient who has had syphilis does not acquire a positive Wassermann reaction for some few weeks, probably about six. We have to remember, also, that the patient will lose his positive Wassermann reaction in the later stages of the tertiary period. So in the earliest and latest stages the Wassermann reaction is not present to be of value to us. It must, of course, be recognised that the Wassermann reaction only indicates that the patient has had syphilis; it does not indicate that the lesion from which the patient is now suffering is syphilitic. We are inclined to be run away with by a specific test like the Wassermann and assume that every lesion is syphilitic in a patient in whom it is positive. There is no reason why a patient should not have a positive Wassermann and tuberculous or other lesions.

As a general pathological process the effect of serum upon blood cells and the factors which control hæmolysis are of great interest. We do not know what are all the factors which control normal hæmolysis which takes place in the spleen. but we do know that when abnormal hæmolysis takes place there is, as a rule, some defect in the spleen, and that this is the chief indication for the removal of that organ. Now hæmolysis may also be produced when alien blood cells are introduced into the human body. In other words, when we wish to give blood from one person to another we have to consider the possibility of hæmolysis. Agglutination of red cells always proceeds and continues, *pari passu*, with hæmolysis. Bear in mind that the ordinary formation of rouleaux must be distinguished from the clumping which takes place with and is a part of hæmolysis.

We now come to the question which was my chief objective when I chose the subject of my lecture to-day, the question of transfusion; when we have to transfuse blood from one individual to another, we must know whether the bloods of the proposed donor and recipient are compatible with one another, for, as has just been pointed out, if they are not, hæmolysis, which may end fatally, will occur. The relative volume of blood to be transfused bears so small a relation to the total blood of the recipient that the former is much diluted, and, even if unsuitable, is prevented by the protective plasma from injuring the cells of the recipient, so what really alone is of practical importance is the effect of the recipient's serum upon the donor's cells.

It was found that by taking a large number of blood tests from a large number of people that all can be classified into four groups. These four groups are represented in percentages of the total number examined, as follows: No. 1, 8 per cent.; No. 2, 40 per cent.; No. 3, 12 per cent.; No. 4, 42 per cent. There is nothing specific about these four groups, which are purely arbitrary. We know that group 1 can receive blood from anybody, and is known as the universal recipient. Similarly, group 4 can give to everybody, and is called the universal donor. Group 1 can receive from anybody, but can only give to group 1. Similarly

group 2 can give to 1 and 2, and receive only from 2 and 4. Group 3 can give to group 1 and 3, and receive from 3 and 4, and group 4, while capable of giving to every other group, can receive only from a group 4 donor. As I have said, in actual practice one wants to test the donor's cells to know whether they are immune to the recipient's serum. So stock sera of groups 2 and 3 are kept at hand, and the donor's cells are tested against these two sera. If agglutination occurs in both, the donor is in group 1; if agglutination occurs in neither, he is in group 4. If one gets agglutination with serum No. 2, he is group 3, and if one gets agglutination with No. 3 serum, one knows he is group 2.

It is obvious that so far we have only gained information as to the grouping of the proposed donor's blood, and, while the same procedure with the recipient's blood will give us his group, the two may not agree. Now, though there is some evidence that it is ideal to give blood of the same group, we know that a recipient of any group can be given blood from a group 4 donor, and as over 40 per cent. of people are in group 4, it is only necessary to go on testing proposed donors until we find one in group 4, which we shall do four times out of ten.

In nearly all American hospitals of any size, and in some of the more enlightened ones in England, proposed donors are grouped beforehand and called upon to give blood when required; this is the ideal system, and should be carried out universally so as to make this line of treatment available for all classes of the community in any emergency.

The only practical difficulty of the above is that group 2 and 3 sera are not always at hand. In actual practice it is quite easy to take some blood from the donor and from the recipient, then to let the blood of the recipient coagulate and take the serum from the coagulated blood and mix it on a slide with the donor's cells. If agglutination takes place, you know you will get hæmolysis if you inject the donor's blood, for, if agglutination is not observed, no hæmolysis will take place. Testing an individual as to which group he belongs to is no less important than testing him for evidence of syphilis by the Wassermann reaction, which should also be done before every transfusion.

You will find it often stated that transfusion should not be attempted unless the donor and recipient have been grouped. I disagree with this view, though it is a council of perfection and need rarely be neglected, still, in my opinion, it is better to take the risk and kill the dying recipient by giving him unsuitable whole blood than by not giving it to him and allow him to die. I think this is a sound rule. We are inclined to be lazy and make excuses for ourselves, saying we could not transfuse because we had not a grouped donor, whereas the truth is that we were too idle or did not know how. During the war the risk, then unavoidable, was often run and very little harm and a good deal of good done. Supposing you select any donor, then it is ten to four against his being in group 4, and therefore no more than even money* that his cells are compatible with the donor's serum. Many of you have in other places taken longer odds successfully, and therefore why not here? You may hurry a man to his death, but, on the other hand, you may save a life brilliantly.

Here is the pulse chart of a woman now in Martha suffering from hæmorrhage, due to a ruptured ectopic gestation; a day or so after her operation she and her husband were grouped, both were in group 4, and she was then transfused with 750 c.c.of blood from her husband. Immediately her pulse fell from over 180 to 140, and within two hours to 120. The effect on the patient was even more dramatic, and, as told me by one of my firm, the transfusion, which was due to the initiative and persistence of Mr. Tanner and Mr. Mullally, acted like a miracle and "obviously saved her life." My only regret about transfusion is that we do not do it enough, and it was with the object of stimulating those who have not seen it done, to go and see it done, and learn how to do it, that I chose this subject for my lecture. It is not at all difficult when you have just got a simple apparatus of the ordinary type.

Now what are the indications for its use? The chief is hæmorrhage. It does not matter whether it is rapid or gradual, but in the latter case it is often so difficult to make up one's mind that the right time for doing it has come. The case I have given of the woman suffering from a ruptured ectopic gestation is a good example of a case of continued bleeding treated by transfusion.

*If donor is not group 4, the smallest group, he can be in No. 1, *i.e.*, 8 per cent.

Transfusion is valuable to diminish the coagulation time in hæmophilia or in any bleeder, such as a purpuric in leucæmic conditions. You can use it to diminish hæmorrhage from a wound. Transfusion is not the slightest use in overcoming the anæmia of sepsis. In the war many pints of blood were given to patients suffering from the anæmia of sepsis, in the hope that this would overcome their sepsis, but the results were unsatisfactory. Another very common indication for transfusion is the state of shock which is so often closely associated with hæmorrhage that some believe it only exists as a result of the latter.

Of course a fall of the pulse rate and the improvement of the patient is the best indication that you have given enough blood. The ordinary adult requires anything between 600 to 1,000 c.c. for an acute hæmorrhage, but for prophylactic infusion not more than 300 c.c. is necessary. Up to 800 c.c. can be taken from an ordinary donor without his turning a hair; after taking 800 to 1,200 c.c. it is best to put the donor to bed for a day or two.

We recently transfused a man in Lazarus who was suffering from recurrent hæmatemesis, of which he ultimately died; about 900 c.c. were taken from his wife who was a frail, delicate-looking little woman, and as far as I could judge without ill-effect on her, as she was not debarred from visiting her husband daily.

One thing which was noticed about several of my cases was the curious cheerfulness of patients after being transfused—it was as if "virtue had entered into them." The disadvantages and dangers of transfusion are usually quite obvious at once. The most serious are not likely to occur if patients are properly grouped; these are precordial pain, dyspnœa and cardiac dilatation. I have not seen one that lived long enough to get hæmolysis. I have no personal knowledge of any danger to donors.

In talking of blood transfusion, I am referring to transfusion with whole blood, which is far better than the citrated method: the patient we want to transfuse has generally a very low blood pressure, and there is evidence that citrated blood adds to that loss of blood pressure. Only those whose experience is small or who are satisfied with "a worse method than the best," use this method in surgical work; its sole recommendation is that the technique is more easily acquired. There is not the same argument against the use of citrated blood in cases where the patient has some disease like pernicious anæmia, but in surgical work we cannot afford to run the risk of a further reduction of blood pressure.

The direct method does not appeal to me at all, as by it one cannot estimate the amount one is giving, and it is very disconcerting to the donor to be compelled to be placed so near to the almost moribund recipient. The only method of which I have personal experience and which seems now to be agreed upon as the best, is the indirect method with Kimpton's tubes, and it is this which you will see made use of in the wards.

A very little practice enables one to coat the tubes evenly throughout their length, and if this is done well the only alleged disadvantage of this method disappears; if there is any tendency for particles of clot to form around the incision in the veins or at the end of the cannula, these can readily be washed away with isotonic sodium citrate solution.

I trust none of you will lose an opportunity of learning to carry out this very useful method of treatment, for I believe that in a few years it will be expected of every well-trained practitioner.

In conclusion I would like to direct your thoughts to the condition known as shock; of the condition of the blood in this state we know very little, and this does not assist us in any practical measure in its treatment. The most marked blood abnormality is a relatively high red count in the capillaries as compared with the venous count; in the former the blood becomes more viscid. Malcolm has shown that the circulating blood volume is reduced by withdrawal of fluid from the general circulation which is now supposed to be retained in the capillaries; this may explain the benefit which results from infusion with saline or blood transfusion in this condition, for by these means the circulating volume is increased and viscosity is reduced.

The only practical means by which we can diagnose that a state of shock exists and by which we can estimate its degree, is by the fall of blood pressure, which here, in place of a normal of 110 mm. may fall to 40 mm., as measured with a Riva-Rocci sphygmomanometer.

It has truly been said that now that anæsthetics have abolished pain, and Lister has driven away operative sepsis, shock remains

the chief bugbear of the surgeon. I think we all need to have this problem more constantly in mind, and venture to address to others engaged in surgical work a plea for the more frequent use of a manometer during operations, so that by increased experiments and observations we may, perhaps, obtain some practical indications of value which will warn us of the approach of shock, and also some hints as to how it may be treated.

Interesting Cases in the Medical Wards

Cases under Dr. Hurst and Dr. Hunt—

Addison	27	Anæmia.
„	31	Ascending myelitis.
Mary	22	Aortic disease.
„	23	Exophthalmic goitre.
„	32	Hysterical spasm.
„	35	Cerebral tumour.

Cases under Dr. Fawcett and Dr. Ryle—

Esther	27	V.D.H.; pulsating liver.
„	33	Phthisis and congenital heart disease.
„	34	Disseminated sclerosis.
Stephen	27	Cirrhosis of liver.
„	42	? Neoplasm pressing on bronchus.
„	43	For diagnosis.
„	46	Aneurism of aorta.

Notice.

Guy's Hospital Medical School.

GULL STUDENTSHIP.

Applications are invited for the Gull Studentship in Pathology and Allied Subjects, which is now vacant.

The Studentship is open to candidates under 30 years of age who have studied in the Medical School of Guy's Hospital, is of the annual value of £250, and is tenable for three years.

Further particulars may be obtained from the Secretary to the Board of Electors, to whom applications must be addressed, at the Office of the Medical School, not later than January 12th, 1921.

The Royal Army Service Corps Memorial Fund.

The General Committee of the Royal Army Service Corps Memorial Fund are prepared to pay the cost, or part of the cost, of convalescent treatment for men who have served in the R.A.S.C. who are medically recommended for convalescent treatment, and are unable to afford such treatment for themselves.

The General Committee would be grateful if Secretaries of Hospitals would bring such cases to the notice of the Hon. Secretary of the Fund, Kensington Palace Barracks, W.8.

Obituary.

Sir Frederick Taylor.

Sir Frederick Taylor, who was born in 1847 in Kennington, was the son of Mr. David Taylor, M.R.C.S., who practised there. After spending his school years at Epsom College, he entered Guy's Hospital as a first year's student in 1863. He graduated at the University of London, obtaining gold medals in Anatomy and Organic Chemistry at the First M.B., and at the Final M.B. he won scholarships in Midwifery and Forensic Medicine, and was marked as worthy of that in Medicine. He took his M.D. in 1870, his M.R.C.P. in 1872, and was elected to the F.R.C.P. in 1879. His first appointment on the Teaching Staff was to that of Demonstrator of Anatomy; he next became Medical Registrar, and was elected Assistant Physician at Guy's Hospital in 1873. For a time he saw Dermatological Out-Patients; he was secretary of the Physical Society, and for a long while Editor of the Guy's Hospital Reports. Almost directly after his becoming Assistant Physician he was made Dean, and retained the office for twelve years He became full physician in 1885, and held this post until he retired from active work in the Hospital at the age of 60 in 1907, when he was elected Consulting Physician. On this occasion his portrait was painted by subscription among his colleagues. It now hangs on the staircase to the Governors' Court Room.

He was for many years Physician to the Evelina Hospital for Sick Children, was also on the Staff of the Seaman's Hospital at Greenwich, the National Hospital for Diseases of the Heart, and the Royal School for Deaf Children.

The chief interests of his life were two—clinical medicine and the welfare of the Medical School of Guy's Hospital; but he found time for other activities. He was President of the Clinical Society, of the Royal Society of Medicine, he was a Senator of the University of London and its Representative on the General Medical Council, he was on the Council of Epsom College and served it in many ways. During the war he worked hard on the Central Medical War Committee.

At the Royal College of Physicians he was Councilor from 1897—1899, and Censor 1904—

1905 and 1910. He delivered the Lumleian Lectures in 1904, taking for his subject Diseases of the Spleen; he was Harveian Orator in 1907, when he pleaded for Research in Medicine. He attained the highest distinction possible by being elected President in 1915. About a year after his election his second son was killed in the war, and early in the next year his wife died; both these severe blows fell upon him at the time of the anxieties of the war and when he was bearing the heavy responsibilities of his high office. Finally, his health gave way; he consequently relinquished all work, and went into the country, where he died December 2nd of this year. A memorial service, at which many of his Guy's Colleagues and most of the Officials of the College of Physicians were present, was held at St. Peter's, Vere Street.

He was created a Baronet in 1917, and is succeeded by his only surviving son, Dr. Eric Stewart Taylor, O.B.E., whom many Guy's men will remember. He was educated at Cambridge and Guy's, and was House Physician to Sir William Hale-White. He served in the R.A.M.C.(T.) during the war, and is now in practice in Hong Kong, where he recently married a daughter of Dr. Calvert, Physician to St. Bartholomew's Hospital.

Few have been better known to Guy's men than Sir Frederick Taylor, for, as we have seen, he came to the Hospital when he left Epsom, and remained as student or teacher till he reached the retiring age of 60. Throughout all this long time his exceptional ability was apparent, and his industry and power of hard work were continuously manifest. These great assets were freely given for the benefit of the Hospital and School. He was Dean when the Medical School Office was in Hunt's building, by the side of the Dispensary door. The number of students was very great; they were quite as numerous as at present. The Dean had nothing like the clerical assistance now provided. There were no typewriters, but Taylor managed the affairs of the School admirably, nothing escaped him, he knew all the students and what each was doing. His devotion to the welfare of the School, exhibited so strikingly during his tenure of the office of Dean, never left him, and until he became Consulting Physician he served on all important School Committees. Here his assistance was invaluable; he had an orderly mind, sound judgment as to what was practicable and what was not; he was an unflinching critic of any ill-considered schemes, and his accurate memory enabled him to tell the Committee the whole history of any subject before it. Whatever success there may have been in the management of Guy's Hospital Medical School is largely attributable to Sir Frederick.

He had a long period on the Staff, and showed himself to be an excellent clinical physician. The power with which he retained in his mind what he had read and what he had seen, his extreme care in the examination of a patient, and his fertility in criticism of suggestions he or others made, usually enabled him, even in the most difficult cases, to arrive at a correct diagnosis. For many years he lived close to the Hospital; he was in and out, day and night, so that as time went on his clinical experience became immense, from which it followed that not many were found so bold as to doubt a diagnosis reached by him. He was wise enough not to write a text-book on medicine in his early days; he waited until his knowledge of his subject was unrivalled, and then produced a book which embraced the whole of medicine. It was an instant success; it has been translated into Italian, and has been through many editions, each revised by the author with minute care, so that it has never been out of date, but has always remained one of the best text-books ever written.

From what has been already said, the reader will be prepared to learn that he was a most careful teacher; when ward clerks first came under him he was insistent that they should begin by knowing the fundamentals, and he spared no pains to attain this end. His teaching of senior students was particularly attractive to them, for he gave freely of his extraordinarily large experience. He never seemed to tire in the wards or elsewhere. He loved exercise, was an alpine climber of distinction and was fond of racquets. Whether at work or play he threw his whole soul into it; happily for us his chief work was at Guy's Hospital.

The following appointments were held by Sir Frederick Taylor at Guy's Hospital:—

1. Assistant Demonstrator of Anatomy, appointed 1870; resigned 1872.
2. Medical Registrar, appointed 1872; resigned 1876.
3. Assistant Physician, appointed February 5th, 1873.

4. Full Physician, appointed May 13th, 1885.
5. Senior Physician, 1900.
6. Lecturer on Hygiene, 1874 to 1881.
7. Lecturer on Medicine and Clinical Medicine, 1873 to 1906.
8. Lecturer on Materia Medica and Therapeutics, 1882 to 1885.
9. Lecturer on Cutaneous Diseases, 1875 only.
10. Dean of the Medical School, appointed 1874; resigned 1888.

Retired, and appointed Consulting Physician, 1907.

Died 1920.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

University of London Athletics.

DEAR SIR,—I was very interested in your reference to University of London Football in your issue of December 11th, 1920.

I quite agree that the traditions behind hospital football clubs are so powerful that men are unlikely to play for the University when their hospital side requires their services.

But it is to be remembered that football is not the only game in which London University is to be represented by a strong Athletic Union, and everything must have a beginning.

The University of London Athletic Union is now under strong hands and things are moving very fast. There is a strong hockey side, and football has already been played against Dublin University. A match is arranged for next season against Cambridge University by a team of London University in its corporate sense. The University of London Union will centralize the social side of University life. The Athletic Union will bring into being for the first time representative Union teams in several games. It is not merely a matter of scattered colleges placing the University at a disadvantage, but it is the fact that the University of London is a great corporate body to move. One college of London University claims to have about as many students as Oxford. Hospital football, though very strong, only represents a small proportion of the faculties of London University. It is believed that London University could put into the field teams that could compete favourably with those of any amateur organisation.

Its hockey side has beaten Oxford this year. Steps are being taken to inaugurate a boating section, and it is hoped that the boat will be on the river in time to pace the Oxford and Cambridge crews in the spring when they come down to tidal waters.

Medicine is such an important faculty in the University of London that it can do much to support University Athletics in all forms. Although, as you say, there are many medical students who belong to no University, which I suppose means that they are not working for a University degree, yet among such are many who are matriculated students. It is the excellent clinical field which attract students to the London Medical Schools from other Universities, on the other hand. The point that a student of a college cannot play for his University unless he be an undergraduate is one that is at any rate debateable.

It is my belief, and that of many members of the Senate, that the development of University Athletics will do very much to cause Londoners to realise what an enormously valuable possession they have in their University, and it is for this reason that I ask those speaking for the hospitals to use their influence to assist in this development.

London is the Imperial University. Its degrees are sought wherever the flag flies. Its athletes should be proud of the purple for representing it.—Yours faithfully,

THOMAS D. LISTER, C.B.E., M.D.,
31, Harley Street, Senator, London University.
London, W. 1.
December 17th, 1920.

Museum of Antiquities.

DEAR SIR,—Mr. Montagu Hopson has recently presented to the Guy's Museum of Antiquities the undermentioned very interesting pictures:—

(1) Photograph of the Senior Dental Students at Guy's Hospital, May, 1891.

(2) Print from the *Daily Graphic*, October 1st, 1890, of the first Conservation Room.

The first-named is the first photograph ever taken of dental students at Guy's.

The second is the original Conservation Room, which was erected in 1889, immediately behind the Fives Court which adjoined Petersham House. Its exact situation corresponded with the women's waiting room in the present Dental School buildings.

Early in 1891 it was abandoned, and together with the Fives Court and Petersham House, demolished to make way for the new buildings.

Whilst these buildings were being erected the Conservation Room was housed in Mary Ward (now

Stephen). This ward had been used for the purposes of the Students' Club, previous to the erection of the college.

The following students may be recognised at work:—M. F. Hopson, F. W. Ta'Bois, H. B. Stoner, P. Harrison and Mr. G. O. Richards; the Assistant Dental Surgeon on Duty.

These may be viewed at any time on application to the Wills Librarian.—Yours faithfully,

GEO. A. WINSTON.

The Wills Library,
Guy's Hospital, S.E. 1.
December 17th, 1920.

Malaria.

SIR,—The able article on Malaria, by Major Hollist in the current number of the GAZETTE will have aroused the interest of all your readers who have to deal with this disease.

During the war one could not fail to be struck by the extraordinary divergencies of treatment advocated with regard to the use of quinine during the attack.

Massive, moderate and minute doses all had their ardent adherents, and methods of administration (oral, intramuscular and intravenous) provoked heated arguments amongst those whose experience of the disease was considerable.

The subject was discussed at great length at meetings of the Salonika Medical Society, but without any sign of unanimity or indeed any proposal to try a uniform line of treatment.

I think the consensus of opinion is that prophylactic quinine is exceedingly expensive and entirely useless, and I doubt if many will be found to disagree with Major Hollist on this point.

How many patients are advised to continue the use of quinine between the attacks with the result that the anæmia and cachexia are increased, the resistance lessened and liability to recurrence considerably increased?

Surely the rational use of quinine in any form should be entirely limited to the period of attack, the interval being utilised to raise the patient's resistance by combating the anæmia and cachexia.

A weekly intra-muscular injection of 3 grains of sodium cacodylate has in many of my cases prevented recurrence—in one particular case (benign tertian) there has been no attack for four months, *i.e.*, since these injections were begun.—I am, Sir, Yours faithfully,

P. SEYMOUR PRICE.

London, S.W. 1.

Dental Society.

THE usual monthly meeting of the Society was held in the College Smoking Room on Tuesday 14th, at 5 p.m., with Mr. E. B. Dowsett, the President, in the chair.

After the minutes of the previous meeting had been read and approved, Mr. G. Parker read a paper on "Resilient Teeth," in which he described a new form of artificial teeth to be used for dentures, the principal feature of these being the fact that by means of a small pad of "Vela" rubber each tooth obtains a measure of elasticity in its attachment, thus imitating the attachment of the natural teeth by means of the elastic periodental membrane. The idea has been worked out in Australia and was generally voted a step in the much-needed improvement of artificial dentures. The lecture was illustrated by means of diagrams and specimens, and Mr. Parker is to be congratulated on the able manner in which he treated the subject.

An interesting discussion followed in which the President and a number of members took part, such points as liability to sepsis, efficacy of the elastic pad, cost of production, effect on the alveolar processes, etc., etc., being raised. After Mr. Parker had dealt with questions and criticisms, the meeting closed. The next meeting is due to take place on 18th January next.

The Annual Dinner of the Society will be held on 12th February, 1921, at the Hotel Cecil, and tickets will be available in January. It is hoped there will be a large attendance. It must be a matter for considerable regret that the meetings of the Society, which form the only link holding the dental students at Guy's together, are not as a rule well attended. Considering that there are about 380 dental students and pupils at Guy's, it seems strange that only 30 or 40, or sometimes fewer members should be present at these meetings which are always interesting and instructive apart from the duty students owe themselves and their profession to learn and discuss the problems which arise from time to time. Surely if one of our dental surgeons, as president, can find time to attend regularly, most students should be able to do so once a month. There seems to be too little keenness in these matters.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Cinematic Surgery.

By W. H. OGILVIE, B.M., M.Ch., F.R.C.S.

CINEMATIC Surgery owes its conception to the brain of Giuliano Vanghetti, an Italian physician, who in 1896 first suggested the possibility of utilising the power of voluntary contraction lying latent in the muscles of an amputation stump, and making it available for the activation of an artificial limb. This freeing of a latent power of movement he called Cinematization. By such means he hoped:—

1. To make use of a source of energy otherwise entirely wasted.

2. To give to the application of power in an artificial limb some of that representation in consciousness which is naturally associated with its application in a normal limb, and which plays so large a part in the physiology of the voluntary muscular system.

3. To replace by far simpler, stronger, and incidentally cheaper apparatus the complicated and delicate arrangements of levers and cords by means of which the movements in artificial limbs must otherwise be carried out, and which have to use as their source of energy the expansion of the chest, the elevation of the shoulder, or some other movement not normally associated with the muscular action which is being imitated by mechanical means.

Being a physician, Vanghetti was unable himself to carry his ideas into practice, and perhaps for the same reason he found some difficulty in communicating his enthusiasm to his surgical colleagues, so that when the war made the question of amputation one of first rate interest and importance, his methods had received very little trial and were almost unknown. Professor Putti of Bologna had, however, taken up the idea, and had already put it into practice in a limited number of cases before 1914. During the war cinematic surgery received a fresh impetus in Italy, while in Germany and Austria several surgeons, notably Sauerbruch of Munich were experimenting on similar lines. A paper by Putti on this subject appeared in the *British Medical Journal* of July, 1918, and being in Italy at the time, I contrived to get sent to Bologna "on special duty," where I had an opportunity of seeing at first hand his work at the Rizzoli Institute. I hope that a short account of these methods, which have as yet been very little discussed, may be of interest to readers of the GAZETTE.

The aim then of cinematization is to utilise the power of contraction of the voluntary muscles of an amputation stump, and for this purpose several things are necessary.

1. That the muscles shall be free to contract and shorten in response to volition. This is impossible in the case of the muscles of an ordinary amputation stump where their distal ends are embedded in the terminal cicatrix, however perfect that cicatrix may otherwise be from the surgical point of view.

2. That the muscles so freed shall have a healthy covering of normal integument, not tender yet possessed of full sensibility, and bearing on its surface no weak scars.

3. That they shall have some means of attachment to the parts of the artificial limb which they have to move.

4. That such means of attachment shall be simple, painless, not liable to cause ulceration, and yet able to transmit the full force of the muscular contraction to its point of application.

These objects are attained by fashioning "motors," as they are called, from the muscles of the stump. Many different procedures have been devised since the method was started, but the motors usually employed are of three main types.

1. "Ansa" or loop motors.

2. "Clava" or club motors.

3. "Tunnel" motors.

The first two have been chiefly used in Italy and this country, the tunnel motor, introduced by Sauerbruch, seems to have been the one most favoured in Germany and Austria. These operations have hardly ever been done in a primary amputation, but nearly always as a secondary procedure on an old amputation stump, the original operation having been for sepsis, gangrene, or extreme laceration. In such cases a preliminary operation is nearly always necessary for the excision of the old cicatrix with all scar tissue and the removal of any possible source of sepsis such as sequestra or foreign bodies. Perfect suture lines and primary union are matters of vital importance in the success or failure of a cinematization.

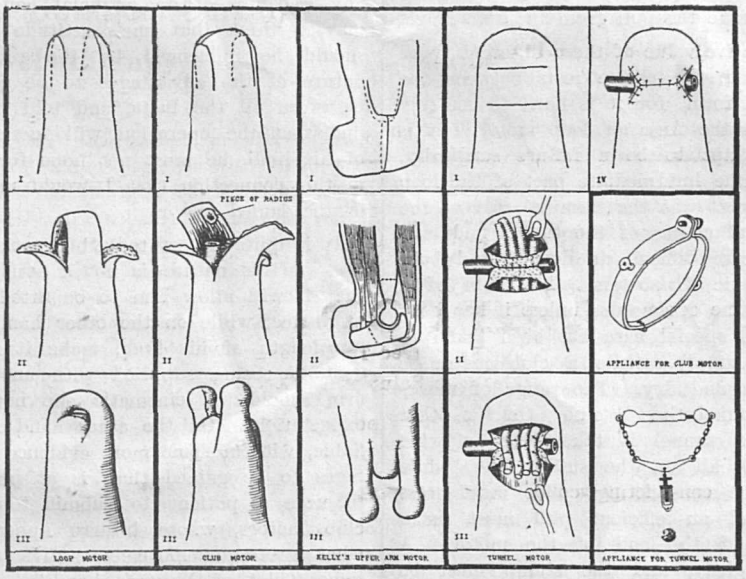
Professor Putti's paper referred to above gives a good general account of the aims of the method. Translations of papers on the subject by various German surgeons appeared from time to time during the war in the review of the foreign medical press published for the War Office by the Medical Research Committee. A monograph by Putti also appeared later containing case accounts and operative details, of which I have an abridged translation which I should be pleased to lend to anyone interested in the subject. The fashioning of the motors themselves is, however, very simple, depending more for its success on perfect asepsis than on any manual skill. The three methods enumerated above can be best illustrated by taking the concrete example of an amputation through the forearm 2 inches above the wrist joint, and seeing how they may be applied in this situation. (See figures.)

I.—THE ANSA MOTOR.

Here the terminal scar is left untouched, and the bridge of fibrous tissue uniting the terminations of the flexor and extensor groups is contained in the loop. Putti's aim in this motor is to preserve the reciprocal action of the opposing groups which is inherent in their normal actions. The incisions are shown in the figures. About 1 inch is sawn off the distal ends of the Radius and Ulna. It is usually necessary to trim up the deeper structures by snipping away some muscular fibres and tendons, so that the edges of the skin covering the loop can be united without tension, and heal with a sound, linear, non-adherent scar.

II.—THE CLAVA MOTOR.

Here again shortening of the bones of the fore-arm by about an inch, and some trimming of the muscles and tendons included in the club, will be required. The terminal scar is, however, excised and only healthy skin used.



III.—THE TUNNEL MOTOR.

The method illustrated is that used by Delitala at the Rizzoli Institute. A bridge of skin 4 cm. wide is raised, and sewn edge to edge with catgut stitches over a rubber tube. The skin above and below is then freed from deep fascia, the tendons divided at their insertion into the terminal scar of the stump, and sutured to themselves at a higher level by interrupted catgut sutures. A few sutures are also inserted attaching the tendons directly to the subcutaneous surface of the skin tunnel. The operation is completed by bringing together the skin above and below the operation site by means of salmon gut sutures. Sauerbruch's tunnel differs slightly from the above. He uses the muscular bellies in preference to the tendons, and the tunnel he favours is constructed from a pedicled flap, which is then pushed through a hole made in the muscle with a large trocar, and sutured to the skin at the other side. Needless to say, in this method the blood supply to the skin of the tunnel is interfered with to a much greater extent.

MEANS OF ATTACHMENT.

The pull of the types of motor above described is transmitted to the working part of the prosthesis by some form of cord, usually either strong catgut or Bowden wire. In the ansa and clava motors this cord is attached to the motor itself by means of a small collar of metal sheathed with vulcanite, hinged at one side and closed at the other with a screw. (See figure.) To obtain a secure pull it is necessary not only that the collar should be a perfect fit, and therefore specially made for each motor, but that there should be a constriction near the terminal end of the motor itself which will give the collar a firm grip. Without this the collar would have to be screwed very tight and even so would be liable to slip, both the tightness and the friction tending to ulceration of the skin of the motor. This constriction can be produced by tying a band tightly round the distal end of the motor during the process of healing, and later by applying the vulcanite collar with increasing pressure for several hours a day. However, the constriction so produced is liable to disappear if the collar is left off for any length of time.

A more satisfactory method advocated in the case of club motors by Fitzmaurice Kelly, is that of

making a kernel in the termination of the motor, so that its end forms a definite knob. In the case of a forearm stump, this may be done by leaving a small piece of the lower end of the Ulna in the flexor motor, and of the Radius in the extensor motor. Some very efficient upper arm motors have been constructed on this principle by Kelly, in cases where a forearm stump had been left too short to allow the natural elbow flexion to move the elbow joint of an artificial arm. Such stumps are a nuisance to the patient and the instrument maker, and are hard to fit with a satisfactory appliance. Here Kelly divides the Humerus just above the epicondylar ridges, and makes motors of the Triceps and Biceps-Brachialis, the former containing the olecranon, the latter the coronoid process of the Ulna. Another method of making a terminal knob is to roll the ends of the tendons into a ball or knot.

The pull of a loop motor is taken by an appliance shaped like a dumbell, also of metal covered with vulcanite, one end being detachable, and both ends fitted with rings. (See figure.) Chains or cords attached to a yoke take the pull from the two rings.

When the comparative value of these different types of motor is examined, the choice rests between the tunnel and the club form, for it is hard to see any special advantage in the Ansa or loop motor. It is unsightly and very apt to be a failure surgically, for the reason that the intermediate part of the loop consists largely of what was the terminal scar of the old stump. The rival claims of the tunnel and club motors are much more difficult to decide, and both have their enthusiastic supporters. The skin of a tunnel is apt to become eczematous unless it has been cut wide and unless special care has been taken to preserve its blood supply, while a club motor is easier to keep clean and dry. The range of movement is less in a tunnel than a club. On the other hand the pull in a tunnel is taken over a wide surface, and not at all on the suture line, while in a club motor the constricting collar must cross the suture line, and an efficient pull must mean some strangulation of the end of the motor. A club motor is unsightly, and the stump must be shortened in its construction.

But one of the most important considerations influencing the choice is one's estimate of the value of Cinematization in general. If it is likely to provide a man with a stump which is really considerably better than before, then questions of æsthetics should not weigh against questions of mechanical efficiency. It is, however, I think, quite fair to say that this premise is so far not proven. A mechanically efficient motor is easy to make. At a meeting in London a year ago about twenty such cases were shown, all of which had motors giving an astonishing power and range of movement. But of the twenty only one had an artificial arm, and he carried it in a parcel! Professor Putti says in his paper that cinematic surgery is only justifiable if it beats mechanical cinematization at every point. That is the crux of the question, and I believe that an impartial observer will be forced to admit that up to the present time it has not beaten mechanical cinematization. At Bologna I saw men writing and striking matches with movements activated by motors made from their flexor and extensor muscles. But a man with a Carnes arm will do the same, and, as far as one can see, do it equally well.

It may be that some improvement on the part of the instrument maker will one day transform this very enticing branch of surgery into a brilliant success. A great deal of experimental work is being done in the workshops at Roehampton with this end in view. On the other hand, bearing in mind the well known fact that a man with complete loss of cutaneous sensibility makes hardly any use of his real hand, it may be that the absence of sensory impulses will always prove an insuperable bar to any real use of an artificial hand. Be that as it may, I think that one's attitude towards a patient should be influenced by the rather problematical nature of the advantages to be gained. He should be given all the facts, and told that while he may find that the operation will increase the usefulness of his limb, he must not hope for too much. It is in this connection that I would urge the advantages of the tunnel motor.

It is quite honest to tell a patient that an operation of this nature is not a serious procedure, and that it will allow him to be fitted with a cinematic appliance, while on the other hand it will not alter the length of his limb, make it unsightly, or prevent his being supplied with an ordinary artificial arm should the cinematic one not come up to his expectations. On the other hand it is hardly justifiable, without some more evidence of definite advantages to be gained than is at present forthcoming, to urge a patient to submit to the formation of club motors, whose bizarre appearance and somewhat grotesque movements give the impression of some "blot of Nature's hand."

I have not touched upon the question of cinematization as applied to the lower limb, but it is fairly generally agreed that this is an unnecessary procedure in view of the excellence of the modern artificial leg.

It is perhaps a necessary corollary of the views expressed above that I have myself only done one cinematization. When the facts are frankly put before them, as I think they should be, most men would rather bear the stumps they have than fly to others that they know not of.

My case was that of a very short upper arm stump which was sent to me because of painful

neuromata in the axilla, and because the axillary folds prevented the fitting of a bucket. Here the pectoralis major had to be sacrificed, and rather than waste it, I detached it at its insertion and folded the tendon round a broad tunnel 1½ inches in length made from the skin of the chest wall mesial to the coracoid process. Surgically this motor was a great success. In six weeks it could pull a weight of 25 lbs. over a range of two inches. The tunnel was dry and painless. If a piece of bandage was threaded through it, the patient could jerk it out of one's hand, in fact it was a source of great joy to him. But owing to persistence of the tenderness, even though all nerve trunks had been divided at the level of the Clavicle, it was impossible during the time that he was under my care to fit him with even a temporary appliance.

A Case of Hysterical Blindness of Four Years' Duration Cured by Psychotherapy.

Charles A., aged 37, was gassed in December, 1916. He remembers falling against the parapet, but from that time his memory is a blank for several months, as immediately after being gassed he was wounded in the head. When he regained consciousness he found that he was blind. After being in various hospitals, he was discharged to his home in June, 1918, at his own request. He received no further treatment and apparently no hint was given that he might eventually recover his vision. In April and May, 1920, he was in Kingston Infirmary for fits, which appear to have been hysterical in nature.

At a board held on July 1st, 1920, he was thought to have optic atrophy and to require nothing beyond ordinary panel treatment. On July 31st a note was made that "it is difficult to know on what grounds he has been sent into the Clinic, unless as a challenge to perform a miracle." On October 6th, however, it was recognised at the Lancaster Gate Clinic that the blindness was hysterical, and he was sent to the Neurological Pensioners' Out-Patient Clinic at Guy's Hospital for treatment.

He was seen for the first time at Guy's on Friday, October 22nd, 1920. He wore dark glasses and kept his eyes closed, but could open them without difficulty. He could barely distinguish light from darkness with his right eye; with his left eye he could just make out large forms, but could not see individual fingers. The right pupil was rather larger than the left; both responded to light. A brisk flinch reflex was present on the left side, but none on the right. Both optic discs were examined by Mr. Eason, and were found by him to be perfectly normal. There was a round opening in the skull near the middle line, in the frontal region. He was very depressed and complained of severe headaches, insomnia, and frequent nightmares. It is worth mentioning that on October 14th, he had accidentally walked into the Thames.

As there appeared to be no way in which the wound could have caused bilateral organic blindness without producing optic atrophy or other physical signs of organic injury to the nervous system, Dr. Hurst diagnosed the condition as hysterical blindness, and told him that he would be cured on the following Sunday. It was again impressed upon him on Saturday that he would be certain to recover his sight. On Sunday, October 24th, it was explained to him as a preliminary that in order to see he must not only open his eyes, but he must also use his brains and look. A little later in the day he rapidly regained his sight, with persuasion and encouragement, and in half-an-hour he could see quite well after having been almost totally blind for nearly four years.

The blink reflex returned at the same time. That night he slept well, his headache disappeared, and next day instead of looking a picture of misery he was alert and cheerful. He required some further re-education before he could accommodate normally, but by October 30th he could read the smallest print, vision being 6/5 with both eyes.

When first seen he looked a typical blind man, with dark spectacles, walking stick, and even a Braille watch. To the ordinary observer he appeared hopelessly blind, and also seemed to be quite unintelligent. Once an accurate diagnosis had been made his treatment was quite easy and simple. He was able to grasp the explanation of his condition surprisingly well, and his hopeless attitude was quickly dispelled by a little persistent cheering up. He was persuaded to look with all his attention at a series of objects of progressively diminishing size as his vision improved, and at each step of improvement attained he was well praised.

After half-an-hour of progressive improvement he could see quite well, and was taken to have a look around London. It is doubtful whether anyone could have guessed that he had been blind in the morning.

His power of accommodation for near objects was re-educated by reading the daily papers. Each day he was able to read smaller print.

I am indebted to Dr. Hurst for his permission to publish this case.

R. D. ROBERTS.

Reviews.

Physical Signs in the Chest and Abdomen. By A. J. Jex-Blake. (Messrs. J. & A. Churchill.) Price 9s. 6d. net.

If this little book impresses on medical students and practitioners that the time-honoured methods of inspection, palpation, percussion, and auscultation must not be neglected in favour of X-ray examinations, blood counts, bacteriological findings and exploratory laparotomies, it may, perhaps, serve a useful purpose. But if, as the author says, one of the secrets of success in diagnosis is to make a thorough routine examination of the patient, the student will hardly be helped in this by a book which deliberately excludes from its purview methods of investigation without which no statement of physical signs could possibly be regarded as complete. Perhaps the author feels he has met this point by referring his reader to "other volumes" in which "these valuable methods will be found described."

Dr. Jex-Blake deals with our old friend I.P.P. and A. very fully, and gives valuable instructions as to the conditions necessary to secure the fullest information from their systematic employment. He avoids the controversies which were the delight of the ancients as to the physical explanations of the various normal and abnormal notes and sounds heard. Some of his statements are clearly open to criticism and would, we feel sure, receive it if made by candidates at the final examination. His explanation of the method of production of cardiac murmurs, and especially of "thrills," would arouse the wrath of some of the teachers in this Medical School. But perhaps some of the things taught in this School might arouse Dr. Jex-Blake's wrath. We note that Dr. Jex-Blake objects to the term "thickened pleura" to describe the condition resulting from old pleurisy, and states that the signs are due to the fact that the lung is adherent. Are they not rather due to the fact that the lung is shrunken?

Initiative in Evolution. By Walter Kidd, M.D., F.R.S.E. (Messrs. H. F. & G. Witherby, High Holborn, W.C. 1.) Price 15s. net.

Twenty-five years ago Weismann, in enunciating the principle of continuity of the germ-plasm, reaffirmed the impossibility of inheritance of acquired characters. For him, no mechanism existed by which such a process could occur. The strength of the position of his followers has always lain in the absence of opposing evidence; positive proof, such as the appearance of a new character, *inexplicable* by use-modification, is almost inconceivable.

The author has devoted many years to the study of the hair-patterns in the coats of animals; the area of hair "brushed the wrong way," which can be seen at the base of the neck of a carriage-horse, is usually attributed to the pressure and friction of the collar; such a pattern he has observed in a similar position on unharnessed foals.

This inherited character, among others, he considers inexplicable on the basis of selection on utilitarian or sexually-attractive grounds, and advances it as a definite modification-inheritance.

Slight as the evidence may seem, if the author's explanation be correct, it is fatal to what he calls the Weismann colossus; the book illustrates the importance of highly trained observation especially where, as in the case of evolution, experiments take place in the wide field of Nature rather than within the four walls of man's laboratory.

Constipation and Allied Intestinal Disorders. By Arthur F. Hurst, M.D., F.R.C.P. (Henry Frowde and Messrs. Hodder & Stroughton, London, 1919.) Price 16s. net.

We owe an apology to the author and publishers of this work, and also to our readers, for the long delay which has occurred in the publication of this review. It is probable that all Guy's men are familiar with this volume of the *Oxford Medical Publications* Series. If there be any who have not read it we can only express the hope that they will do so at an early date. The publishers of medical works have kept our reviewers unconscionably busy during the two years since the cessation of the war, but of all the mass of literature that has come to hand during this period there have been comparatively few books that can be so cordially recommended to the medical profession as Dr. Hurst's "Constipation." He has selected a subject which, while of paramount importance to the practitioner, has received scant attention from authoritative writers. The writers of the standard text books do not include constipation in their list of diseases. Rather they deal with it as a symptom. Although it is true that constipation is a common and distressing symptom of many conditions that are recognised as clinical entities it is surely equally true that it is the primary cause of much disease and suffering and, as such, it deserves a place amongst those diseases that have long been regarded as specific. The fact that practically every patent medicine puts forward as its chief claim upon the public that it "cures constipation" is sufficient testimony to the almost universal distribution of this complaint.

Dr. Hurst is at pains to point out that this is in reality practically a new book and not a second edition of his previous work that bears the same

title. He treats his subject in a systematic way with a lucidity that is too rare in contemporary medical literature. Although Dr. Hurst's material is based largely on his own researches, carried out here at Guy's with the help of numerous students and other Guy's men, an excellent bibliography is also included which should prove of real service to those who wish further to investigate a subject now for the first time placed upon a sound scientific and clinical basis.

Atlas of the Sensory Cutaneous Nerves. By William Ibbotson, M.R.C.S., L.R.C.P. (The Scientific Press Ltd., London, 1920.) Price 7s. 6d. net.

This Atlas contains nothing new or original. Its contents can all be found in the various text books, but it has a real value in spite of this. It compresses into one volume matter which is distributed fairly widely in the literature of the central nervous system, and for this reason should prove useful to those who lack time and opportunity for detailed study of such works but who, at the same time, require to refer frequently to the material which Dr. Ibbotson here supplies. For disturbances of sensory nerve function are becoming daily of greater diagnostic significance. Perhaps in the near future the information contained in this volume will be familiar to all practitioners. At present this is not the case, at any rate amongst a majority of medical men. By such this Atlas of the sensory nerves will be welcomed as a valuable addition to their collection of works of reference.

Oto-Rhino-Laryngology for the Student and Practitioner. By Dr. Georges Laurens. Authorised English Translation of the Second Revised French Edition, by H. Clayton Fox, F.R.C.S.(Irel.), with a foreword contributed by J. Dundas Grant, M.A., M.D., F.R.C.S. (Messrs. John Wright & Son, Ltd., Bristol.) Price 17s. 6d. net.

In a highly specialised branch of medicine such as oto-rhino-laryngology, it is obvious that any book which demarcates with any degree of success the provinces of the specialist and general practitioner will prove to be of the greatest value. Dr. Laurens' work sets out to do this and succeeds admirably in every way. An extensive ground is covered and the information conveyed is accurate, condensed and eminently practical. The text is full of that extraordinary detail which is characteristic of the best French writers. The concentration on details in treatment, the abundance of excellent diagrams, and the general soundness of the advice given, are only a few of the points upon which this book may claim to be the superior of the great majority of similar works in this country. Many practitioners and students will find in this book an active stimulus to study a branch of their work which is often found difficult and irksome, and will find welcome help under the heading of "What to Avoid"—in many instances a matter of major importance.

Venereal Diseases: Their Clinical Aspect and Treatment. By J. E. R. McDonagh, F.R.C.S. (Messrs. Wm. Heinemann, Ltd.) 1920. Price £3 3s.

The first thing that strikes one on opening this book is that there is no preface, but the last chapter doubtless contains all that the author would have said had he elected to write one. The major portion of the work is devoted to syphilis; then follows a chapter on soft sore, which includes an interesting account of ulcus molle serpiginosum, with some excellent illustrations and case-histories of this rare condition, and eight chapters are concerned with gonorrhœa and non-gonorrhœal urethritis. The book concludes with six chapters on "subsidiary venereal diseases" (under which heading are included balanitis, condyloma acuminatum, molluscum contagiosum, herpes genitalis, granuloma inguinale, induratio penis plastica, and pediculosis pubis), on sexual neurasthenia, on venereal disease and marriage, venereal disease and public health, the relationship of syphilis to malignant disease, and the bridge between the clinical and pathological parts of the venereal domain. Some of these later chapters are among the best in the whole volume.

As is well known, the author regards the spirochæta pallida as merely the adult male gamete of a coccidial protozoon—the "leucocytozoon syphilidis"—the life-history of which, according to his descriptions, is comparable to that of other parasitic protozoa, such as the malarial parasite. His view is not generally accepted at present, and his ingenious arguments in its favour must be considered very critically. The fact that the spirochæte can be cultivated on artificial media, and its rapid multiplication in experimental chancres seem to us to be points against it being merely a male gamete. The author considers that in experimental chancres only "the extracellular development of the male body occurs," and that the test-animal is comparable to the culture tube, and he points out that, whereas experimental chancres always have the same clinical appearances, the sore of human syphilis shows numerous clinical varieties. Moreover, he thinks that in some chancres only the asexual stage of the leucocytozoon syphilidis develops. It seems to us that the clinical variety of human sores may depend on individual differences of reaction in the tissues of infected persons rather than on differences of development of the infecting organism.

The clinical descriptions of the various forms of chancre, and of the skin lesions in the secondary or

generalisation stage are good, and the coloured plates are, on the whole, beautifully done. The recurrent syphilitic eruptions, which certainly seem to be commoner since the arseno-benzene preparations have been employed, are also well described.

A very important chapter is that on the biology of syphilis of the nervous system. Figures are quoted to show that nervous syphilis is on the increase. This is partly due to the increased strain put upon the nervous systems of people in civilised countries during recent years, and partly, according to the author, to the influence of treatment on the incidence of syphilitic nervous affections. He does not think there is any convincing evidence in favour of there being special neurotropic strains of the infecting organism, or of it having of late developed a greater affinity for nerve tissue.

As regards the influence of treatment on the incidence of nervous diseases, the author insists that the organism reaches the central nervous system at about the same time as the secondary rash appears, and that this invasion occurs in about 70 per cent. of all cases. The protective substances for the nervous tissue proper, *i.e.*, apart from the meninges, circulate in the cerebro-spinal fluid; part of these protective bodies come from the blood-stream (systemic portion), and therefore, if this be sterilised early in the secondary stage, the production of antibodies is checked, and the nervous system is likely to suffer. The reason why parasyphilitic nervous disease is rare in many native races is because with them the treatment is so inefficient that antibodies are seldom absent from the systemic part, and therefore the organisms in the nervous part are prevented from developing.

In the section on treatment, the various drugs used in the treatment of syphilis, and the methods of their administration are first considered. The toxic symptoms that may arise from arsenic and mercury are then described and discussed, and the value of intramine in combating them is emphasised. Finally, the methods of choice in the treatment of the various stages of the disease are given, with some special remarks on syphilis in women, congenital syphilis, and diseases of the nervous system, in which the author believes that constant tapping of the cerebro-spinal fluid within one-and-a-half hours after injection of arsenobenzene is as efficacious as giving intraspinal injections.

With regard to the section on gonorrhœa it is interesting to note that urethroscopy is condemned as being of very little value in diagnosis, no help in treatment, and of considerable danger to the patient. Some good pictures are provided of Keratodermia blenorrhagica, in which condition the author has found lymphocytosis in the cerebro-spinal fluid, and he assumes it to be due to meningeal irritation of the trophic fibres in the posterior nerve roots caused by the toxin of the gonococcus. The chapter on the chemotherapeutic and vaccine treatment of gonorrhœa will doubtless meet with a good deal of adverse criticism from those entitled to pronounce an opinion upon it. We confess that we were not able to understand very much of it.

We are in complete agreement with most of the author's views upon venereal disease and marriage, and venereal diseases and public health. He points out very clearly the futility of relying upon the Wassermann reaction, or upon a negative bacteriological test for gonorrhœa in deciding whether a person who has had venereal disease may marry. On the other hand he is convinced "that a venereal infection is rarely conveyed to another party except during the acute stage."

The chapter on syphilis as a poison and its relationship to malignant disease is a remarkable one, but the author's pathology, like his biochemistry, is often beyond us, though there is no denying their ingenuity.

On the whole we regard his book as a real achievement; it is the work of one who is not only a specialist in venereal disease, but also a very competent dermatologist. And, if his theories invite destructive criticism, his clinical experience is so great that his book should most decidedly be read.

Surgical Aspects of Dysentery. By Zachary Cope, B.A., M.D., M.S., F.R.C.S. (Messrs. Frowde, Hodder & Stoughton.) Price 12s. 6d. net.

The tendency to forget surgical lessons of the war is as regrettable as it is natural. Mr. Zachary Cope's excellent little volume will serve to remind many of us of a chapter of experience, the details of which were all too carelessly noted at a time when material of interest abounded. Truly the business in hand was too pressing for thought of the then far distant future; but, in view of the present pathetic sharing of each attractive case at our centres of observation, any reflection on the missed opportunities of a few years ago must necessarily excite remorse.

Although dysentery is by no means a scourge of the past, few of us will again have a chance of observing its results in more than isolated cases. Incidentally, one wonders why certain research enthusiasts fail to take a trip out East. Not only are the manifestations of a disease such as dysentery of absorbing interest, *per se*, but also are they likely to throw a light, if scientifically observed, on wider problems such as those of rheumatoid arthritis.

At the outset, Mr. Cope refers to the simulation by dysentery of various surgical conditions. This is of great importance; it is in fact perhaps too well recognised by tropical surgeons, and one has

seen several cases of non-dysenteric appendicitis including abscess, cholecystitis, tuberculous peritonitis, and at least one case of carcinoma of the colon labelled dysentery on that account.

The surgical treatment of dysenteric colitis and the whole subject of liver abscess are admirably reviewed; the indications for surgical interference are very fairly stated. An eminent physician at Guy's dogmatically asserts that no case of liver abscess demands drainage, and the same physician is quoted as asserting that appendicostomy, etc., ought never to be necessary in amœbic dysentery. His experience, if extensive, must have been fortunate. A minor point, to which there appears to be no reference in Mr. Cope's book is the remarkable resolution, after exploratory needling, of certain cases of amœbic hepatitis that have failed to respond to emetine, in spite of the fact that no pus may have been found.

The phenomena of dysenteric arthritis are worthy of considerable study. It is, perhaps, a trifle disappointing to find that amœbic dysentery, contrary to our own impressions, is discarded as an ætiological factor, for here was a new starting point in the consideration of arthritis; but the opinion is backed by so great an authority as Sir Leonard Rogers. No mention is made of the occasional cases which culminate in a suppurative staphylococcal lesion. However, the account given is good, though brief.

A valuable monograph, without claiming to be exhaustive, it is none the less readable on that account; it bears the stamp of experience and critical observation.

The work of the publishers leaves nothing to be desired.

A Handbook of Midwifery. By Comyns Berkeley, M.D., F.R.C.P. (Messrs. Cassell & Co., Ltd., London.) 5th edition. 1920.

To the pupil midwife Dr. Berkeley's book, the 5th edition of which reaches us from Messrs. Cassell & Co., needs no recommendation, for it has been her main standby since its first publication fourteen years ago. With the exception of the chapters on artificial and breast feeding the present edition contains little new material—and indeed none is needed. We could wish that more stress had been laid on four-hourly feeds from the first. We believe that this practice might be almost universally adopted with great benefit both to mother and baby.

The chapters on the management of labour are very skilfully dealt with, and these should prove useful to the extern as well as to the pupil midwife, although, of course, much that is included in the earlier chapter (on anatomy and physiology) would (or should) be superfluous to the former. The continued popularity of this book is assured.

The Early History of Surgery in Great Britain. By G. Parker, M.D. Medical History Manuals. (Messrs. A. & C. Black, Ltd., London.) 1920. Price

This is an attempt, and very successful attempt, to trace briefly the progress of surgical art from the year 1000 A.D. up to the middle of the last century. Limitation of space necessitates brevity, but the result is a most interesting little volume dealing with an aspect of social history—at all times a fascinating study—of which little is known, at any rate by the general public and the medical profession. To those unfamiliar with medical and surgical history, the early chapters describing the state of surgery nearly 1,000 years ago will come as a surprise. They will learn with amazement of the high standard of proficiency that had been attained in those early days, and will be interested to hear that many of our present day problems were troubling the ancients just as much as they trouble us to-day.

There seems to have been much separatism in those days. Surgery and medicine were separate subjects, and there appears to have been some jealousy between the physicians and surgeons. At any rate they had not acquired that cooperative spirit which, even in the twentieth century is not always as apparent as one could wish. De Mondeville, a thirteenth century French surgeon, is described as employing a technique anticipatory of Lister's teaching 500 years later. "A wound left in contact with air suppurates"—"Beware that your hands are clean or they will infect the wound"—"Do not allow the wound to bleed." That is teaching which contains at any rate the beginnings of asepsis.

We could go on quoting indefinitely. But we must leave our readers to enjoy these pages for themselves. They will find much to interest and amuse them. The pictures are excellent and Guy's men will be glad to find the historic picture of Thomas Guy discussing the plans of the hospital with the architect and Dr. Mead, the physician.

Many a well-known name is mentioned in the later chapters dealing with the eighteenth and nineteenth centuries. Here we learn that Percival Pott fell off his horse and fractured his own fibula (with dislocation) afterwards describing the condition in his "Remarks on Fractures and Dislocations." John Hunter, Astley Cooper, Abernethy, and a host of others come in for honourable mention. Altogether it is a most instructive, interesting, and well written book, which will amply repay perusal.

The Industrial Clinic. By Edgar L. Collis.

We regret that we omitted to mention in our review that this book is published by Messrs. John Bale, Sons, and Danielsson. The price is 10s. 6d.

Papers by Guy's Men.

R. P. Rowlands, M.S., F.R.C.S., Ureteral Stones.—*Clinical Journal*, xlix., p. 100.

R. P. Rowlands, M.S., F.R.C.S., Carcinoma of the Stomach.—*Ibid.*, p. 172.

H. C. Cameron, M.D., F.R.C.P., The Differential Diagnosis of some Continued Fever.—*Ibid.*, p. 197.

R. O. Moon, M.D., F.R.C.P., Intra-thoracic Aneurysm.—*Ibid.*, p. 211.

E. C. Hughes, M.S., F.R.C.S., Caricinoma of the Rectum.—*Ibid.*, p. 225.

A. Ralph Thomson, Ch.M., F.R.C.S., Traumatic Stricture of the Urethra in Children and Young Subjects: the Immediate Treatment of Ruptured Urethra.—*Ibid.*, p. 309.

E. G. Slesinger, F.R.C.S., The Treatment of Compound Fractures.—*Ibid.*, p. 321.

R. P. Rowlands, M.S., F.R.C.S., Time in Surgery.—*Ibid.*, p. 345.

H. W. Barber, M.A., M.D., B.C., Herpes Zoster.—*Ibid.*, 349.

Sir Arbuthnot Lane, Bart., M.S., F.R.C.S., Cancer of the Colon: Its Causation and Treatment.—*Lancet*, December 11th, 1920, p. 1184.

J. A. Ryle, M.D., M.R.C.P., and H. W. Barber, M.D., M.R.C.P., Gastric Analysis in Acne Rosacea.—*Lancet*, December 11th, 1920, p. 1195.

A. H. Harkness, The Superiority of Sodium Antimony Tartrate to Emetine in Bilharzia.—*British Medical Journal*, December 11th, 1920, p. 890.

C. P. Symonds, M.A., M.D., M.R.C.P., Optic Neuritis in Encephalitis Lethargica.—*Lancet*, Dec. 18th, 1920.

J. Joffé, B.Sc., F.R.C.S., and E. P. Poulton, M.D., F.R.C.P., The Partition of CO_2 between Plasma and Corpuscles in Oxygenated and reduced Blood.—*Journal of Physiology*, liv., p. 129.

J. M. H. Campbell, M.B. and E. P. Poulton, M.D., F.R.C.P., The Relation of Oxyhæmoglobin to the CO_2 of the Blood.—*Ibid.*, p. 152.

J. M. H. Campbell, M.B., and E. P. Poulton, M.D., F.R.C.P., Arterial CO_2 Tensions.—*Ibid. Proceedings*, p. xlix.

Appointment.

A. Ernest Sawday, M.B., B.S.(Lond.), to be Anæsthetist to the Derbyshire Royal Infirmary, Derby.

Football.

GUY'S "B" v. ST. MARK'S COLLEGE, CHELSEA.

Played at Honor Oak Park on Wednesday, December 8th. Owing to the thick fog, and late start, the greater part of the game was played in semi-darkness. Hirschberg opened the scoring for Guy's after a good run by Young, and later scored again from a break through by Seward.

In the second half tries were scored by Craib, Hirschberg, and Aung, the latter being a fine individual effort.

On account of the bad light, and the greasy state of the ground, the game was mainly confined to the forwards, in which department Guy's more than held their own. Final score: Guy's "B" 17 points, St. Mark's College nil.

Guy's Team.—Daneel (S. H.), March, Craib, Hirschberg, Young, Aung, Seward, Currie (Capt.), Ive, Estment, Orsmond, Berry, Amm, Mill and Jacobson.

GUY'S v. LONDON WELSH.

We found a very slippery surface at the Herne Hill track for this match on December 11th. Our opponents could not turn out before 3 p.m. so the end of the game was very much in the gloaming. The Welsh were not at full strength and as we never are in these days, little can be said on that score—but we miss J. A. Krige and H. Graham-Davies. C. L. Steyn and P. K. Albertyn are both fine substitutes but we want them on the wings again, where pace is so necessary. Albertyn played very finely though on the afternoon under notice; Steyn could not keep his feet and he did not run straight, and again both he and Van Schalkwijk get rid of the ball ever so much too soon. Our threes so often in action were confronted again and again by three to two, simply because the stand-off half failed to draw or get by his man. We were a long time opening the score sheet. Daneel ran splendidly on two occasions but just failed, and the referee's whistle seemed rather obtrusive on other occasions. Van Zyl, most useful in the line out, toppled over with a try which Neser, after a no charge was sounded, magnificently converted. Several times Bekker swung the ball out, but the threequarters were not made the best use of, too much kicking, and it was left for L. K. Watson to score the next try after a fine run of some distance.

Ends were changed and it became difficult to see things, occasionally Doherty could be seen and heard, Marais appeared in the mist tackling with much heartiness, and Watson was ever on the ball. Frequently the passing went to the right, but Weinburg could not get over, and the centres put on a

try apiece which Neser made excellent but unsuccessful attempts to add to. Once or twice the Welshmen broke through, to find Van Heerden sound, though his worth would be greatly enhanced if he could kick for touch with the left foot. A fine dash for the line with three Guy's forwards on the ball was well stopped by L. J. Evans. Our men still kept up a hot attack, the passing went to the left and back again to the centre where Albertyn dropped a very fine goal indeed. Wilkins got away and punted hard, but a penalty against us for obstruction ensued about 5 yards inside the 25 yards line. A. W. Witts, whom both Kriges know, took the kick which, well directed, just went distinctly outside the upright. The opposing touch judge waved his flag for a goal. The referee asked him if it was so and apparently was told "yes," but P. J. Krige, the Guy's touch judge, informed the referee that the ball was not kicked over the bar, but to the left of the upright.It was a very bad light, but the mistake was very difficult to understand as from the pavilion one could plainly see it was no goal. Our last try came from Van Heerden charging down Witts' kick and following up to score a remarkable 3 points, no conversion following. Final score: Guy's 21 points (1 goal, 1 dropped goal and 4 tries), London Welsh nil.

Guy's Team.—H. Van Heerden, A. Daneel, P. K. Albertyn, C. L. Steyn, L. Weinburg, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, C. Marais, F. W. Reitz, H. Van Zyl, E. E. Neser, R. F. H. Duncan, R. M. Macintosh, L. K. Watson.

GUY'S v. OLD MILLHILLIANS.

Played at Southgate, December 18th, and with more than our usual allowance of crocks and men unable to take the field. F. Bekker and J. G. Van Schalkwijk, to whom congratulations are due, were playing at Leicester for the South versus the English XV. in the second international trial. Rumour and the press had stated that P. K. Albertyn was on the reserve list but confirmation has been lacking. Not but what he is quite up to international form, and one feels a little surprised he was not in the list of chosen. He is the exact type of player wanted for the Welsh match, and his skill and knowledge of the game are unquestionable.

It would be best to look at the list of players to see who was in the field. The game opened sensationally, Sprong throwing out a long pass which Albertyn handed to Daneel who scored in the corner within a couple of minutes of play commencing. Neser failed with the kick. The subsequent play was not quite concert pitch, several times our opponents cut through, and some of the tackling was too high. The neck is too high a place to go for, and a tackle there is generally slipped, that is unless the neck is broken. Van Heerden saved several times, and if the attackers got through neither Steyn or Albertyn spared themselves in getting back. The forwards did not do so well in the tight, and very seldom did the threequarters come into the picture, except for chances they picked up themselves. Just before half-time Meacock and partner got the threes away, but alas Albertyn's final pass was forward. Just before half-time Reitz got over and as Neser's kick was wide we had two tries to our credit at half-time.

The second half found the forwards better, but in the scrums they were often beaten for the ball and Meacock's job was not enviable. Sprong appeared to be distressed through injury. Taylor and Watson both played very finely, and if Taylor was not fit it will be a pleasure to see his play when he is. The referee was unfortunately a great musician, anyhow, as far as whistle solos go, but it didn't make the game fast or even open. All were pulled up if they got away. In some close work by the line Van Zyl gained a try for Steyn to neatly goal, and soon after Sprong got over with a straight swift run. The forwards were now hustling to some purpose, and getting play close to the Mill Hill goal-line James managed to pick up and score neatly. Crook was unsuccessful with the kick but he converted Sprong's try. A kick-off from the centre was allowed over again. Taylor caught the ball and got clean away, but a whistle back sounded and a scrum ordered in midfield, why I cannot think. Towards the end we were distinctly on top, but nothing could be done without a scrum being ordered, no doubt quite properly, but with many friends and acquaintances, Guy's men and others, there was not one of us that could understand the various awards as the game drew to a close. Result: Guy's 2 goals 3 tries (19 points), Old Millhillians, nil.

Guy's Team.—H. Van Heerden, R. James, P. K. Albertyn, C. L. Steyn, A. Daneel, S. P. Meacock, E. L. Sprong, F. W. Reitz, E. E. Neser, H. Van Zyl, F. J. Biddle, L. K. Watson, C. Harvey, H. Taylor, F. W. Crook.

What little came the way of James he shaped well. If the forwards had pushed more, Sprong stood further back and the threequarters spread themselves in proper echelon, we should have done better.

GUY'S HOSPITAL v. FITZWILLIAM HALL, CAMBRIDGE.

Played at Cambridge on Saturday, November 27th, 1920. Reserves were called in to fill the wing half positions, but otherwise the team was at full strength. Guy's having won the toss, at once began to press, both Nicholls and Van Geuns being unsuccessful with early shots. Play was carried into midfield, but soon

returned to the vicinity of our opponents goal, and following a combined attack Williams scored at the end of ten minutes play. Shortly after the re-start the opposing forwards broke away, their centre forward equalising. From this point onwards the Fitzwilliam attack played a fast game and looked very dangerous whenever they gained possession of the ball. After some midfield play Van Geuns took the ball on the run, after it had been passed forward between the backs, but unfortunately his shot went just outside the upright when the goal-keeper was beaten. Our opponents centre forward scored twice in quick succession, his first goal following good play on his left wing, his second being the result of a solo effort. O'Meara was injured and retired till half-time, Van Geuns coming out of the forward line to fill his position at centre-half. Play now settled down in midfield till half-time, both teams showing signs of tiring.

During the second half our forwards were for the most part attacking, being very unlucky not to score on two or three occasions. A hot shot from Trott was pushed over the bar for a corner; the resulting kick being headed over by our forwards. Shortly afterwards Van Geuns kicked a centre from Morgan into the goal mouth, but the ball bounced back into play after hitting the underside of the crossbar. Our opponents attacked again and scored, Hardy being given no chance. We again pressed, and Nicholls with only the goal-keeper to beat shot straight at him. Our forwards forced two corners but these were also cleared. Just on time Fitzwilliam scored again, leaving the final score 5—1 against us.

Guy's Team.—Hardy, Wakeford, Riddolls, Trafford, O'Meara (captain), Hewetson, Van Geuns, Nicholls, Williams, Trott and Morgan.

The one pleasing feature of this game was the play of our forwards, who, both individually and as a whole, showed more initiative and combination than they have in any previous game this season. They attacked from the outset, and with even moderate good fortune should have scored more than once. Van Geuns, Williams and Trott were the pick of a good line. The kicking and tackling of the defence was very weak, the wing to wing passing of the opposing forwards being always a source of trouble to them. Hewetson alone played up to usual form, his tackling especially being very effective. O'Meara was undoubtedly put off his game by his injury in the first half.

Hockey.

GUY'S v. DULWICH.

A most interesting game was witnessed at Forest Hill on Saturday, 11th December, when Dulwich were winners by 8 goals to 7.

B. M. Tonkin scored the first goal for Guy's, but this initial success was followed by a period of about twenty minutes during which the Dulwich forwards did exactly as they liked with our defence. A. L. Pemberton played a brilliant game and scored 4 goals, while N. Parkinson scored 2. The score was now 6—1 against Guy's in a comparatively early stage of the game, and it was fortunate indeed that our team showed more signs of stability in the latter part of the first half, and D. C. Eglinton having added a point for Guy's, half-time was reached with the score 6—2 against us.

The tables were turned, however, in the second half when our forwards—for whom J. V. Schollum and B. M. Tonkin were always conspicuous—carried all before them, goals being added in our favour by J. V. Schollum 2, B. M. Tonkin 1, J. R. A. Moore 1, and D. C. Eglinton 1. At the same time A. L. Pemberton was still a source of grave danger to our defence, and by scoring twice in the second half gave Dulwich the victory by the narrow margin of the odd goal in 15.

As the score indicates, the goal-keeping on both sides was weak, but some useful work was seen by the backs on both sides, G. T. Yarge and N. K. F. Porter being most noticeable for Dulwich and C. G. Bowen for Guy's. The whole of our defence was deplorably weak in the first part of the game and the dashing exhibition of our forwards in the second half alone saved us from a severe defeat.

Guy's Team.—C. T. V. Baugh, C. G. Bowen, W. F. Hurdle, H. Shepherd, J. R. A. Moore, S. C. Olver, J. E. Duckworth, J. V. Schollum, B. M. Tonkin, D. C. Eglinton and L. E. Owen.

Other Results—

Dec.. 11th.—Guy's II. v. Dulwich, lost 2—10.

Dec.. 8th.—Guy's A. v. Kingston Grammar School, won 8—0.

The first matches in the next "half" are, Jan. 8th, Guy's v. Wallington, at home, and Guy's II. v. Broxbourne, away.

Birth.

TA'BOIS.—On November 20th, 1920, at "Winfield," Woodford Green, Essex, the wife of Fred. W. Ta'Bois, L.D.S.Eng., of a son.

Marriage.

SOUTHGATE—KIRBY.—On the 27th November, at the Church of St. Bartholomew-the-Great, Smithfield, Herbert W. Southgate to Margaret E. Kirby.

Ed.—M. E. S.